



# THE MODERN HOSPITAL

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## WHAT IS GOOD OUT-PATIENT SERVICE AND HOW CAN IT BE SECURED?\*

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THE two essential elements in good out-patient service are accurate diagnosis and adequate treatment. A hospital can provide good out-patient service if those who are in control of that hospital seriously desire that it render such service and are willing and able to furnish those things which are necessary for adequate diagnostic work and for adequate therapy.

What do we mean by accurate diagnosis? Not the scientific labeling of pathological findings but rather the correct appraisal of the conditions which the patient presents—an appraisal which is the product of accurate observation and professional skill and which alone can form the basis of adequate treatment.

What do we mean by adequate treatment? The bringing to bear upon the conditions affecting the patient of processes which will cure or remove those conditions, or, if cure is impossible, will minimize their destructive and debilitating effects, and the carrying of those processes through to completion.

By the foregoing statements we mean simply this: For the patient who presents himself to an out-patient clinic it is the business of that clinic to diagnose correctly his condition and to give him effective treatment. Does this mean the

setting up of too high a standard for dispensary medical service? Certainly not, if we put the interests of the patient first. In fact, one might well say that this is only a minimum standard. But, though it may be the purpose of every hospital and dispensary to diagnose its patients correctly and to treat them adequately many fall far short of doing it, as you and I well know. And worse than this inadequacy, is the fact that to most of those who could correct it, it is a matter of no great concern.

As has already been suggested, a hospital cannot provide good

out-patient service unless its board of directors, its superintendent and its medical staff seriously desire that it do so. A hospital is an organization and the ideals of those who make up that organization determine the quality of what it produces. The chief reason why there is so much out-patient service that is not good is that boards

### Satisfactory Service

IF OUT-PATIENT departments are to assume their definite place in hospital service they must offer, as Mr. Ransom points out, accurate diagnosis and adequate treatment. There must be the same degree of excellence as is exhibited in the in-patient service. It is quite important that the out-patient staff be made up of men of ability and that the facilities needed for adequate treatment be readily available for the use of the staff. The whole administration, and the board of trustees must cooperate in maintaining this department. In addition to furnishing the needed facilities, they must see that the physicians who devote their time to such work receive fair compensation for the time and effort given to such services.

\*Read before the Hospital Association of Pennsylvania, Pittsburgh, April 3, 1924.

of directors, superintendents and medical staffs have other interests and responsibilities which in their minds are far more significant.

### Fundamental Needs for Good Service

It is quite natural that the work of the hospital proper, as distinguished from its out-patient service, has secured the larger share of interest and attention. The in-patient services are available for and are used by people from every walk of life—the rich, the middle class, and the poor. They are used by all ranks of physicians for all classes of their patients. The hospital provides for the physician the facilities through the use of which he practices his art and earns a considerable part of his income. On his part, the staff physician obligates himself to render medical service to the ward patients of the hospital. It is of interest to the patrons of the hospital, to the staff, to the board of directors, to the superintendent and to all others concerned, that the staff be composed of able physicians and that all the facilities which the staff needs in order that it do high-grade medical work be readily available. The adequacy of a hospital's facilities together with the professional ability of its staff determine in large measure that hospital's standing in the community, its patronage, its income and other matters of vital importance.

What we have just said applies to the hospital's service in relation to its private room and ward patients. But in the interests of its out-patients it is quite as important that the out-patient staff be made up of men of ability and that the facilities needed for good medical service to ambulatory patients be readily available for the use of the staff.

But perhaps because the out-patient department serves only the poor, because the men of superior staff rank have few out-patient clinic responsibilities, because the quality of its out-patient service has little or no relation to the hospital's income-producing patronage and perhaps for other effective reasons, there may come to prevail in a hospital an unexpressed but generally accepted idea that it is not especially important that the out-patient service have the same degree of excellence that is set for the rest of the work of the hospital.

But a hospital has no right to do inferior out-patient work. If it cannot render good out-patient service it should not attempt to render any at all. A hospital is essentially a unit and one standard of excellence must be maintained throughout all its services. If careless, slipshod work is permitted in its out-patient clinics, it will be impossible to confine entirely to those clinics all work

of that quality. Perhaps it is not going much too far to say that one may form a fair opinion of the sincerity of purpose of a hospital by ascertaining the quality of its out-patient service.

If a hospital has an out-patient department, it is the responsibility of the board of directors and the superintendent to learn, if they do not know, what good out-patient service is, what they must do in order that their hospital render service of that quality, and what means and methods they must devise that they may be kept informed concerning the quality of the service their out-patient department is rendering. So far as the board is concerned, a committee of its more active, alert, industrious and insistent members may well be intrusted with the fortunes of the out-patient department.

### Adequate Facilities Needed

Further than this, the board must be willing to spend money on its out-patient service. Too frequently those who are interested in other phases of a hospital's work are more efficient in securing appropriations for their purposes and projects than are the sponsors of the out-patient clinics. Perhaps with the insistent demands upon the hospital board for more money than it can produce for needs, all of which seem vital, it is hardly fair to imply that the correct measure of a hospital's interest in its out-patient department is the money it spends in equipping and maintaining it. But there are instances in which such an implication seems justified. If a hospital accepts out-patients it is the solemn responsibility of its board of directors to see that they are adequately cared for.

It is the responsibility of the superintendent of the hospital to see that the work of the out-patient department is properly conducted and supervised. If the demands upon his time are such that he must delegate much of this responsibility to an assistant or other subordinate, he must see to it that that subordinate is thoroughly conversant with out-patient administration and that he has amplitude of time and intensity of interest sufficient for his important task. But the superintendent himself must be thoroughly interested in the out-patient service of his hospital, and his contacts with it must be sufficient to insure its efficient administration and of such a nature as to promote its morale.

However, the best efforts of the hospital administration to provide good out-patient service can avail nothing without the whole-hearted cooperation and support of the medical staff. It is one thing to demand service in out-patient clinics as a part of a staff member's obligation to the hos-



pital. It is quite another and a different matter to so organize and conduct an out-patient service that the staff and the administration are united in a common endeavor to give that service the best possible quality. There are conditions which must be met if such cooperation is to be expected.

#### Fair Compensation for Physicians

The first condition is one of compensation. To be sure, it is one of the time-honored traditions of the medical profession that the physician give of his service to the poor. But conformity to this tradition does not insure that a physician will do any very considerable amount of work in an out-patient clinic without a fair compensation. I do not mean that he wants a salary. Nor do I forget that there is a limited number of medical men who find satisfaction in out-patient service even though they can no longer expect to derive any benefits from their service. Satisfaction is a form of compensation. If a hospital wants to attract good men to its clinical service and to obtain good work from them, it must see to it that for the time and thought and energy which those men invest there shall be a fair return in things that will make for their professional advancement.

Just the opportunity to see a large number of patients is by no means enough. The young physician will be well compensated if he can carry on his diagnostic work in the out-patient clinic under the direction of abler men from whom he believes he can learn. If attending men and associates on the staff are available for this service in the out-patient clinics and have that fine generosity of spirit with reference to teaching and consultation work which we have come to recognize as an attribute of the really great physician, that hospital will have no difficulty in attracting the most promising young men to its clinical staff and in securing good service from them.

#### Opportunities for Specialty Practice

The out-patient clinic may offer to the young physician his first opportunity for training in relation to specialty practice. It is a well-established principle of medical education that the undergraduate course, even including the fifth, or intern, year must be devoted to the general training of the future practitioner. It is also held by many medical authorities that a few years of experience in general practice before one attempts serious preparation for specialization are highly desirable. Excepting perhaps major surgery, all the well-defined specialties are represented in a general out-patient clinic. If the out-

patient department is well-equipped, if its older and abler physicians are really desirous of helping to train men in their respective special fields and if the institution fosters such a function, the out-patient clinics will afford excellent opportunity for at least a part of this specialty training.

The out-patient service of a hospital, if properly organized, can afford to its staff some opportunity for investigative work. Both the needs of patients and the interests of physicians seem to encourage the establishment of a growing number and variety of special clinics. To name cardiac, gastro-intestinal, metabolism, protein-sensitization, and mental hygiene clinics is to mention only a few of these more highly specialized clinics now frequently to be found in our larger out-patient departments. These afford excellent opportunity to the physician who may desire to study some special problem in which he is interested provided, of course, that the institution is far sighted enough to see that by giving the physician the service he requires to carry on this investigative work it is not only helping him but it is at the same time furthering its own interests in providing better service to its patients.

#### Provides Excellent Training Ground

Then again, the hospital will attract able young men to its out-patient department if it recognizes good service in that department. The hospital can with safety assure those physicians who have only out-patient relationships to it that when vacancies occur in the lower ranks of its staff proper, it will give first consideration to men whose abilities and other qualifications have been demonstrated through their out-patient service. In fact the hospital may well use its out-patient department as a training ground for the prospective members of its major staff in which it can, as it were, bring them up schooled in its traditions, loyal to its service and interested with it in making the hospital progressively approximate its possibilities.

However, promotion from the out-patient clinics to service in the wards should not mean a graduation from the former. There should not prevail the idea that service in the out-patient department is a purgatory through which the physician must pass in order that he may reach that more desirable place—the ward service. If the young physician who joins the out-patient staff does not develop or demonstrate ability that would warrant promoting him to ward service he should not be permitted to continue long on the clinical staff. Incompetency cannot be tolerated in a good out-patient clinic. Some arrangement

ought to obtain in a hospital by means of which the out-patient physicians need not lose all contact with or knowledge of the patients they refer from their clinics to the wards. Lack of opportunity to follow up what are probably his most interesting and valuable cases is not conducive to the expenditure of the out-patient physician's best efforts.

The hospital must not have a niggardly attitude towards the demands of the out-patient staff for service. X-ray and laboratory service, social service, dietetic service and the like should be just as readily available for this department as it is for the other services of the hospital.

I should like to state more clearly what I have already implied that the hospital must not only demand that good work be done in its out-patient department but that it must find a way in which it may know whether or not good work is being done. It is becoming more and more apparent that hospitals need to develop means and methods of measuring their product or output. We need to give our patrons something more concrete and tangible than that, through the expenditure of a certain sum of money, we furnish a certain number of days of hospital service and that a certain other number of visits were made by patients to our out-patient department. We ought to be able to report something of what we accomplished for those patients. We must find ways of evaluating and perhaps of modifying our processes in the light of a better knowledge of what those processes produce in relation to the life and health of our patients.

#### Inadequacy of Control of Patients

Inherent in out-patient work, as it is now organized, are certain conditions which must be controlled or otherwise overcome, if the best service is to be rendered the patient. Chief among these is the inadequacy of control of the patient. If the physician is to make an accurate diagnosis it may be necessary that he make a number of observations of a patient's condition and symptoms. He may have to make certain diagnostic tests the efficacy of which depend upon the patient's willingness to cooperate in carrying them out. This may entail the making of a number of visits to the clinic before the real treatment stage is reached. Then as to treatment, if the patient is to get the maximum of benefit from it, there must be the fullest cooperation on his part in following instructions and in keeping up the treatment process until it is carried to completion.

This degree of cooperation is difficult to secure. The dispensary patient usually looks for immediate results. If they are not apparent he loses

interest and stops coming. Much depends upon the physician. He can have a greater influence with the patient than can any other person. But he can exert that influence effectively only if he takes the time to explain to the patient what he wants him to do, and establishes such a relation with the patient that he willingly follows the directions given him. Most persons who are sick wish to be well and if properly handled will cooperate with the physician to the limit of their intelligence.

#### Social Service Department Needed

Though the physician is the most potent factor in securing the cooperation of the patient, there are many ways of supplementing his efforts. An out-patient clinic will have a greater degree of success if it has an efficient follow-up system. Out-patients frequently present difficult social as well as medical problems. Medical treatment may be ineffective unless the patient has assistance in solving these social problems. Hence, if a hospital is to render really effective service to these patients it must have a social service department.

Another untoward condition to be found in many out-patient clinics is that of overcrowding. We have no right to expect his best work from a physician if we demand that he see more patients than he can adequately examine and treat. If the demands are greater than the staff can meet, the hospital must increase its staff, limit its intake of patients or so distribute its work as to keep the number of patients a given staff man is required to see under the limit which efficient service sets for itself.

There exist in all cities today a considerable number of agencies and institutions which serve in various ways the same clientele as do hospital out-patient clinics. Some of these agencies work in the closely allied field of public health; others are concerned with child welfare, family rehabilitation and the like. The work of these agencies like that of the hospital is of great value both to the individuals they serve and to the community. The success of much of this social work is dependent upon the ability of the various agencies to obtain adequate medical service for the persons they seek to serve.

Individual and family rehabilitation cannot be wisely planned unless the agency which must formulate and carry through the plan can find out what are the physical and mental disabilities of the persons they would serve, and secure competent advice as to what must be done in the light of those disabilities. This is a service which those agencies are coming more and more to seek from

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dispensaries and hospital out-patient clinics. It entails additional work on the part of those institutions, but it greatly enhances their community value. The out-patient institution that wants to make its work count for most to its patients and to the community which supports it will develop the means of providing this cooperative service to these other agencies. In like manner, it will make use of them in relation to the needs of patients who present problems of the kind those agencies can help solve. Hospitals that have good

social service departments can best carry out this function.

There are many other things which a hospital can do to increase the value and effectiveness of its service to ambulatory patients. But perhaps inclusive of all of them is the general principle that the hospital must take its out-patient department seriously, believe in the value of the service which can be rendered there and see to it that the quality of that service is in conformity with the highest ideals of the hospital and of the medical profession.

## CHESTER COUNTY HOSPITAL, WEST CHESTER, PA.\*

BY YORK & SAWYER, ARCHITECTS, AND S. S. GOLDWATER, M.D., CONSULTANT, NEW YORK, N. Y.

**S**ITUATED on the crest of the hill northwest of the City of West Chester, well removed from crowded streets, the Chester County Hospital is permanently assured of good light and air. The architecture, inspired by the simple country villas of northwestern Italy of the XV century, will have a character distinctly rural and domestic. The hospital will form a picturesque crown to the hill from the approach on Boot Road. Since economy of construction is the masterword in hospital work, the style is particularly appropriate, for its character and dignity are dependent upon symmetry and careful study of wall and window relations rather than upon ornamentation. The walls of stucco, relieved by stone band courses and trim, and the roof of red tile, are characteristic elements.

There are two points of view from which a

hospital building may be considered: first, the architectural point of view, and this we have just dealt with; second, the standpoint of use. What does the building offer in the way of service conveniences? What are its values to those who will administer it and to the patients who will occupy it?

### Avoidance of Waste Fundamental

One of the most important considerations in the planning of a hospital is to avoid waste, to erect a building which will be economical both in construction and in operation. This requires that every foot of floor space be utilized to advantage, and that the various departments be so grouped as to facilitate their operation independently and collectively.

The building is "T"-shaped, with the stem of the "T" pointing north, and the two arms (each expanded at its extremity) extending east and west. The patients are accommodated wholly in the two arms of the "T," which correspond archi-

\*The authors acknowledge indebtedness to those who contributed fruitful suggestions during the preparation of the plans, especially to Mr. P. S. Du Pont, the donor of the building; Mr. Samuel Marshall, of the building committee; Dr. Sharpless, Mr. James N. House, hospital executive; Mr. Shoenizohn, consulting engineer, and Mr. W. M. Francis, in charge of construction.



Perspective of the Chester County Hospital, West Chester, Pa.

tecturally to the main front of the hospital, which faces south by southwest. Only a negligible fraction of the patients' beds occupy rooms having a northern exposure; the majority have a southern exposure, and a considerable proportion east and west. The loggias, which to patients have an importance only second to that of the wards, face the south, where they will be fully exposed to the prevailing breezes in the summer and to the low winter sun, and will afford unobstructed views of the picturesque country.

The patients' beds are distributed over three floors. The third floor, which is intended for private and semi-private patients, contains single rooms, and semi-private wards holding two beds or three beds each. The visitor approaches these rooms by means of elevators which face a central lobby; at this point, the nurse's control station is located. A corridor eight feet wide penetrates the length of the building and is directly ventilated by a window at either end; in addition, this corridor receives direct ventilation by means of two side passages leading to the loggias. Such conditions are most favorable to natural ventilation, and will go a long way toward dissipating the odors which tend to collect in hospital corridors less carefully planned.

#### Utility Rooms Close to Patient Rooms

Each wing of the building has a fully equipped utility room within comparatively easy walking distance from any patient's room, the average distance being twenty-five feet. Linen cupboards, as well as utility rooms, are duplicated in order to save time and steps. Separate toilets and baths are provided for men and women. Adjoining one of the utility rooms is a sanitary clothes chute. A spacious pantry or ward kitchen occupies a central location, and is entered from the side corridor. The pantry is close to the food lift or service elevator, and its location on the side, not the main, corridor will tend to confine the noise and odors which are inseparable from kitchens.

To promote quiet, a retiring room has been set aside for those special nurses whose presence in patients' rooms may not be required. The entrance to this room has purposely been placed opposite one of the loggia passages, not opposite the door of a patient's room. Three suites with private baths and vestibules constitute an important special feature of this floor.

On the second floor, directly beneath the private rooms, are the women's wards (surgical, medical, and maternity), and the children's wards. The largest wards hold eight beds, but these are subdivided by glass screens into cubicles each

holding two beds. By placing a portable screen between any two beds, single cubicles can be readily improvised. The full partitions between the eight-bed wards and the central corridor are largely glazed. One effect of this is to add greatly to the cheerfulness of the northerly ward. In the second place, supervision will be facilitated, for the nurse's station is placed at the extremity of the open corridor, midway between the two eight-bed wards, from which point of vantage the nurse can control the approach to the wards and at the same time have under supervision all of the beds in both wards.

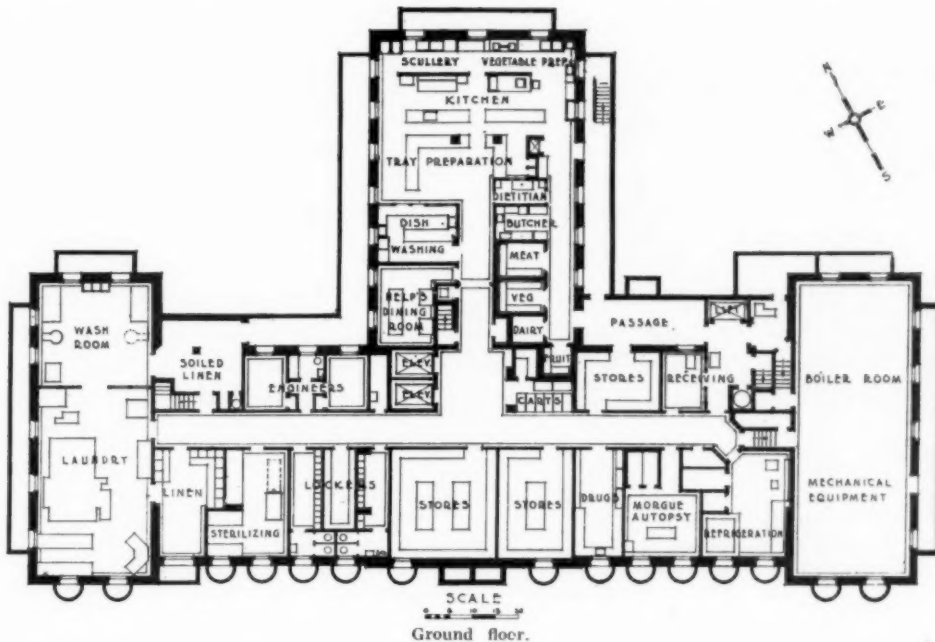
At the eastern extremity of the main wing are the medical and surgical wards for women. At the western extremity, occupying similar space, are two eight-bed wards for maternity cases, subdivided into cubicles in the manner already described. Adjoining each of the main wards is a separation or quiet room, and semi-private ward of two beds. On the opposite side of the corridor are three additional single rooms which may be used either as private or separation rooms for ward patients. Toilets and baths are provided for the maternity service at one end, and for the women's medical and surgical service at the other. The utility room equipment is the same as on the floor above.

#### Play Room for Children

The central south front is occupied by the children's ward service, which commands a play room, two wards of six beds each (separated from each other by a glazed partition), a utility or sink room, toilets, and baths, the latter including a tub bath and a horizontal spray bath. The children's wards are located at a considerable distance from the adult wards, which location, it is believed, will contribute to the comfort of the adult patients on this floor; furthermore, from a sanitary standpoint, it is important that the children's wards be self-contained; thus, without entering the main corridor, access can be had from either ward to the sink rooms, bath rooms, play room and to whichever loggia may be assigned to the children. The pantry on this floor is equipped with a pasteurizer, a dish sterilizer, and ample refrigerators.

An important feature of the maternity ward is, of course, the nursery for new-born children. The location of this is important, as any woman knows who has occupied a maternity-ward bed in a hospital. In the present plan the nursery is located on the side corridor. It is subdivided into a larger and a smaller section, so that sick infants may be separated from those that are well. In order to preserve a uniform temperature in





Ground floor.

the nursery, which requires, especially in the winter, a higher temperature than the rest of the hospital, it is entered through a vestibule. The babies' washing and changing room connects directly with the nursery, and is equipped to enable several nurses to work in it at the same time. To minimize the danger of infection, a small "septic" ward, with its own bathroom and toilet, has been provided.

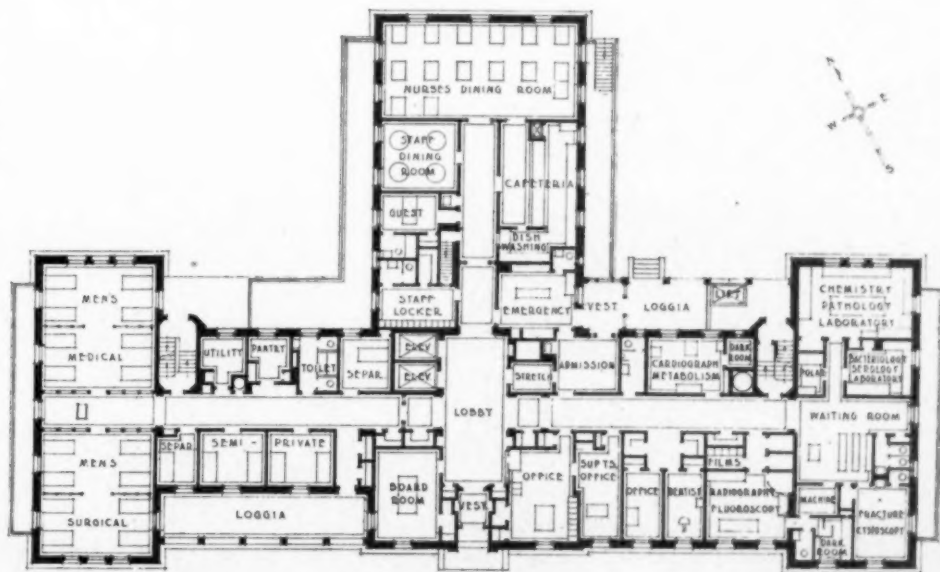
Only one-half of the main wing on the first floor has been set aside for patients. The program called for male surgical and medical wards, corresponding with the female medical and female surgical wards above, but the children's and maternity wards which are found on the second floor are not repeated, a large part of the first floor being utilized for administrative and laboratory purposes. The men's medical and surgical wards correspond in detail to the women's wards above. The major wards hold eight beds each, and adjoining the wards are two semi-private wards of two beds each, and two single or separation rooms. A loggia is likewise available.

The roof story affords an isolation section for the resident medical staff; here are four single rooms for residents or interns, a sleeping porch, and a common lounge.

We have referred chiefly to the front part of the hospital building. The rear, or northern extension, is to be the service section. On the third floor, there is a nurses' locker room assigned for the use of non-resident and special nurses. The remainder of the third floor of this wing is given over to surgery; and the plans speak for themselves. The entire "surgery" has a tile floor and wainscot, and a ventilating system of its own.

Directly beneath the operating rooms are two birth rooms with a connecting sterilizing room. The birth rooms, as well as a preparation room for maternity cases, open on a vestibule which is separated from the main corridor. As physicians will frequently wish to spend the night in the hospital when in attendance on maternity cases, a room for their accommodation has been set aside close to the birth rooms. Nearby is a dressing room for the nurses employed in this division.

Recognizing the importance of first impressions, some care has been taken in the treatment of the main entrance. This has an arched doorway, trimmed with stone, and recessed, having a porte-cochère to afford protection from the elements. The hospital is entered through a vesti-



First floor.

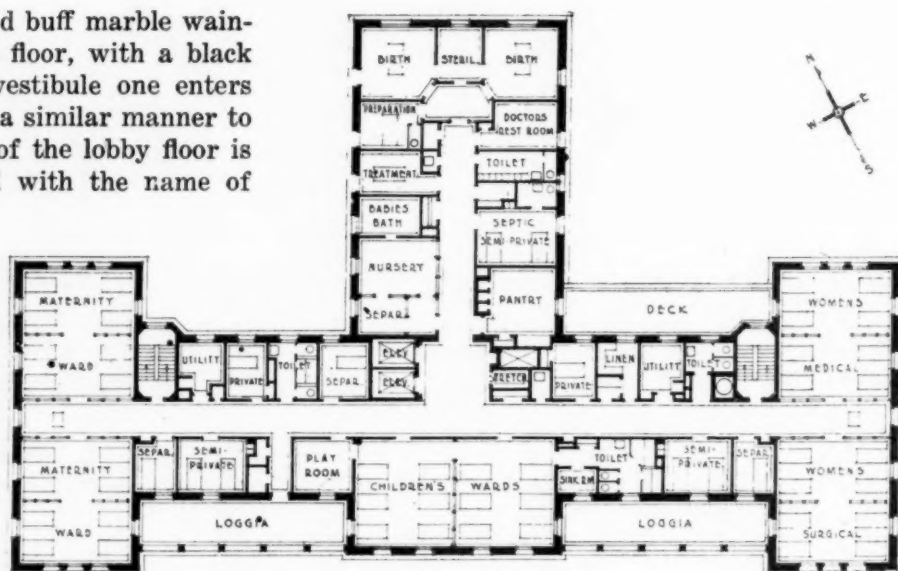
bule with a vaulted ceiling and buff marble wainscot and a travertine marble floor, with a black mosaic border. From this vestibule one enters the lobby which is treated in a similar manner to the vestibule. In the center of the lobby floor is a bronze medallion inscribed with the name of Lewis Mason to whose memory the building is being erected.

Passing through the vestibule, the visitor finds on the right an information desk and counter; on the left, the entrance to the reception and board room. The visitor, whose destination is one of the upper floors, crosses the lobby to the elevators just beyond. To the left are the male wards. On the right, the open corridor, continuous with the central lobby, is the route to the main office, the superintendent's private office, and the office of the directress of nurses. Opposite the main office is an admission room which may also be entered from the ambulance entrance in the rear. The ambulance vestibule connects not only with the admission room, but with an emergency treatment room. Patients may be wheeled from the admission room directly through a side passage to the elevator, without crossing the main corridor.

#### Laboratories on First Floor

From the standpoint of medical service, the first floor is of great importance, for here are the x-ray department and a compact laboratory suite, equipped for chemistry, pathology, bacteriology, and serology. The principal chemical and bacteriological laboratory is entered through a side passage; it is lighted by windows at two sides, and exhaust ventilation through a fume hood will avoid the spread of laboratory odors into the main corridor. Two additional departments located on this floor, are the electro-cardiographic laboratory, and the department of dentistry.

The northerly wing of the first floor, which lies beneath the operating rooms and above the kitchen, is utilized chiefly for dining room purposes. The principal, or nurses', dining room is forty-two feet by twenty-two feet, and is lighted on three sides. Immediately adjoining the dining room is a well-equipped serving room, connected by a dumbwaiter with the kitchen directly underneath. The dishwashing room adjoining the cafeteria is cut off from the main corridor. In addition to the main dining room, there is a smaller



Second floor.

dining room, fifteen feet by sixteen feet, for the staff. A guest room with a private bath will enable the hospital to accommodate, in emergencies, any patient's friend who desires to remain in the hospital during a critical illness.

#### Domestic Service on Ground Floor

The domestic service of the hospital is concentrated on the ground floor. Wide areas on either side of the kitchen assure ample light for this important section. The laundry has been similarly treated. The kitchen is in the rear, under the dining rooms. A freight lift will bring supplies from the ground level to the kitchen floor. For the handling and checking of supplies, a receiving and shipping room and a receiving clerk's office have been provided. There are general, as well as food, storerooms, the kitchen storerooms including space for dry groceries and a series of spacious refrigerators for fruits, vegetables, dairy products, and meats. In logical sequence are arranged the receiving room, the storerooms, the meat preparation room, the vegetable preparation room, and the kitchen proper. The scullery and the vegetable preparation room are separated from the main kitchen by a low screen. Ample space has been reserved for the preparation of trays, with separate counters for the service of hot and cold food. The dietitian's office overlooks the kitchen and is close to the tray preparation space. The dishwashing room is placed between the service elevator and the kitchen, adjoining the tray preparation space, and is partitioned off from the kitchen proper. A dining room for the help has been placed on this floor in the neighborhood of the kitchen.

Next in importance to the kitchen as a ground



floor feature is the laundry. A clothes chute delivers soiled linen directly to the soiled linen room. This opens into the wash room, which has windows on two sides, and which connects directly with the laundry proper. Adjoining the laundry is a large room divided into sewing space and clean linen storage and sorting space. Nearby are rooms for the sterilization of mattresses and patients' clothes, and for the storage of mattresses and pillows.

It was thought advisable to provide, for the engineer and engineer's assistant, two small bedrooms with a connecting bath. For non-resident employees, male and female, locker rooms and toilet accommodations have been provided.

The only sections of the ground floor which have immediate relation to the medical administration are the pharmacy and the morgue; the latter has mechanically cooled mortuary boxes.

In the easterly extremity of the basement, one finds the boiler room, containing two 125-horsepower, oil-burning, horizontal-return-flue, tubular boilers. The oil storage tank will be outside the building and accessible from the service drive. The usual mechanical equipment in connection with the boiler plant, and the tanks, pumps and filters of the plumbing system are installed to the south of the boiler room. The electric current will be supplied from the street service. Adjoining the boiler room is the refrigerating plant for cooling all the refrigerators throughout the building and for ice making.

#### Adequate Natural Ventilation Provided

Owing to the extremely favorable conditions for natural ventilation, a minimum of mechanical ventilation is installed. Exhaust ducts are provided from the toilets, utility rooms and pantries, discharging through a fan on the fourth floor. Separate systems are provided to ventilate the operating suite, kitchen and laundry.

The building is 192 feet front with a maximum depth of 115 feet, containing approximately 807,000 cubic feet. The building is planned to accommodate sixty ward beds, twenty-eight beds in two and three-bed rooms and twenty-one single and private patients' rooms, giving a total patients' bed capacity of 109. There are also bedrooms for the engineer and assistant, a suite for the superintendent and four rooms for interns. The nurses and help are to be housed outside.

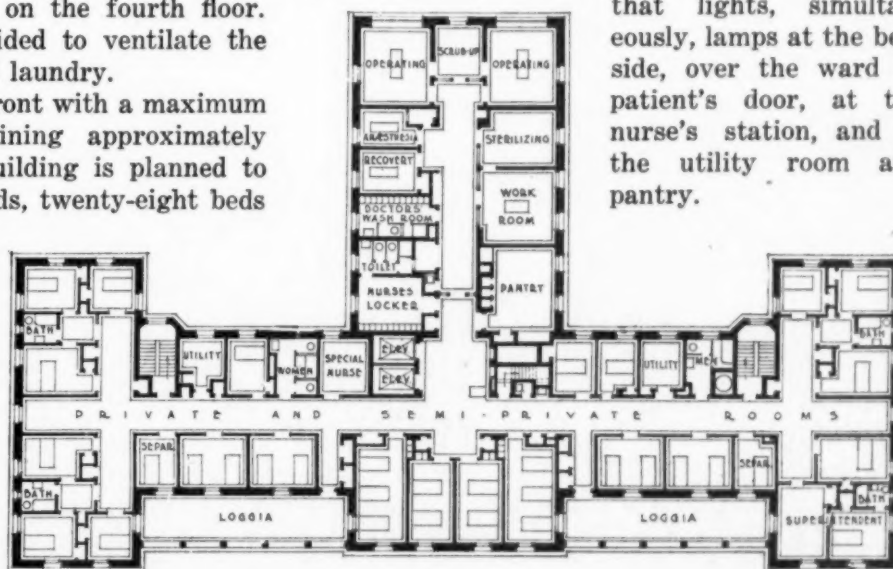
The building will be con-

structed of fireproof material except the roof framing which will be of wood. Hollow tile will be used for exterior walls and partitions, while the floor construction will be of reinforced concrete beams with terra cotta block filling. All horizontal steam and plumbing pipes and brine lines are hung from the floor construction and concealed by a hung ceiling. At all control valves, access doors are provided in the ceiling or on the walls, set flush with the plaster.

The door frames are of drawn steel, flush with the plaster. The outside windows and doors are of wood. Window sashes are designed with a wide bottom rail, allowing the lower sash to be raised several inches before the bottom of the lower rail is above the stool. This allows considerable ventilation at the meeting rail without a draft on the patients.

In the corridors, wards, single rooms, dining rooms, and in the cardiograph and metabolism room the floor and base are of terrazzo, the floor being divided with brass jointing strips. The operating and maternity suites, utility rooms, pantries, baths, toilets, and similar rooms have a gray, vitreous tile floor and a glazed tile wainscot. Quarry tile is used for the floor of the kitchen department and in the laundry and laboratories, while the floor in the offices, dentistry and in the radiography room is of linoleum laid over cement. The boiler room, storerooms and other rooms of this character have cement floors. The walls and ceilings throughout the building will be painted in neutral tones to harmonize with the terrazzo and gray tile. Narrow bands of a deeper shade of the wall color separate the wall and ceiling tones.

The patients may call a nurse by a system operated by a push button at the patient's bed, that lights, simultaneously, lamps at the bedside, over the ward or patient's door, at the nurse's station, and in the utility room and pantry.



Third floor.

## IMPROVING HOSPITAL FINANCIAL RECORDS\*

By R. N. BROUGH, COMPTROLLER, NEW YORK POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL, NEW YORK, N. Y.

**T**HERE is a widespread belief that modern accounting records are a product of civilization during the last three or four centuries, arising from the manner in which business was conducted in the early days of this country. Of necessity the early settlers bartered one commodity for another, and did practically without currency. Such transaction as took place required no records because each was complete in itself. However, when money was introduced occasions arose, as they do today, when a person did not have the ready cash to pay for the purchase at once. Then credit was established and in order not to forget the transaction the seller sometimes fell into the practice of making a memorandum of it in a rough and ready fashion. Tradition says that in England during the Dark Ages the custom arose of writing such memoranda in chalk on the walls of the dwellings. Hence arose the expression, still sometimes used by those desiring credit, "Chalk it up."

But even though such primitive methods were in use during fairly recent years, it has been established that partnerships existed in Babylonia as early as 2200 B. C. Drafts and checks were used and legal decisions recorded covering accounts of all sorts. The records of banking and financial firms of Babylon and other cities have been preserved on sun-baked tablets or slabs. In Greece public officials were required to give strict accounting for all transaction; in early Rome banks used books in which individual accounts were kept, customers being debited on one page and credited on the other. Double entry accounting (now universally employed) was first adopted in Italy beginning about the thirteenth century, with the result that some rather elaborate systems

of bookkeeping were established as early as 1350.†

### What Proper Records Reveal

A few moments' reflection will reveal why financial records are almost as ancient as civilized mankind. In a very real sense they tell a story. If prepared in proper form they give us the history of a business in the most complete, exact and concise form that the wisdom of mankind has been able to devise. With that thought in mind, the accounting profession is proceeding on the theory that financial records of any business or enterprise "should . . .

*present a clear picture of the financial operations and the conditions of affairs, at a minimum effort and expense."* This point has been driven home so far as to establish almost as an axiom that no business can be conducted to the best advantage unless its operations are accurately mirrored in clear financial records and statements.

Nor is that the only aspect of the matter to be considered. There is in addition a duty to the public. Almost without exception our front-rank medical schools and institutions caring for the sick are not operated by the

owners of the properties but by officials who practically act as trustees. Certainly the contributors who by unstinting generosity have founded and endowed such hospitals and who today are liberally giving toward their maintenance or the enlargement of their fields of usefulness are entitled to full and accurate statements of the manner in which their funds have been spent or are being handled. In my opinion, they should be regarded in the same light as stockholders of a corporation and given similar information accorded such individuals under the laws of most of our states. Viewed from even a broader standpoint, it would be well for us to remember, when pre-

### Cost System Needed

"Practically all modern industrial concerns have long realized that a cost system in conjunction with financial accounts is essential for accurate figures and proper executive management. It is strange that this fact has not been more broadly recognized among institutions."

"How many of our hospitals today can really tell what the cost of maintaining a semi-private patient has been for a given period? How many know the actual cost of maintaining a surgical ward in comparison, for instance, with a babies' ward?"

"Departments sometimes believe that they are operating at a profit when actually a real loss is being sustained. The facts are unknown because figures have not been prepared on a scientific basis."

\*Read before a staff conference, New York Post-Graduate Hospital.

†Accountants' Handbook, page 1234.



paring reports and financial records, that we are established for the fundamental purpose of serving the public, and that we can well do so by giving special care to the perfection of the written history of our trusteeship.

Very few who have had experience along this line will contradict the statement that a straightforward, comprehensive, carefully prepared financial report attracts the eye and brings its own reward. A demonstration of this point may be had by turning to the reports currently published by banks and insurance companies. Not many years ago these were usually prepared in a manner difficult for the average citizen to understand clearly as they were presented in such dull, concise, balance-sheet form that only those having special training or knowledge could grasp the significance of the figures. Today a noticeable change is taking place. Many of our progressive companies spare no effort or expense in the preparation and publication of their reports, which are so skillfully drawn and clearly written that even the uninitiated can secure in a few moments an intelligent idea of the financial position. Now in many respects hospitals and other institutions bear a similar relation to the public as do banks and other companies mentioned. They exist for the purpose of serving and helping the community or large portions of it. Their real success depends upon public good-will and support and, furthermore, they have nothing to lose and everything to gain by strengthening confidence in the efficiency of the administration.

### Preparation of Financial Records

Keeping these observations in mind, let us see how they work out in practice. It is easy to talk about clear, comprehensive, accurate statements of a business; securing such a product is a horse of another color.

First of all, in our presentation of the facts, we must keep the audience in mind. The history used in the grammar school is vastly different from the one which finds favor in the university, even though it may clearly and accurately state the same facts. Financial statements desired by boards of directors and perhaps by the public, though excellent in many respects, may be unsatisfactory to others. As a usual matter, trustees or directors are interested particularly in the final results. They do not always care for exhaustive details, as the time available for the consideration of the financial statement may be greatly limited. Generally speaking, the reports to be rendered to such bodies should be highly condensed and prepared in such a manner as to bring out the important facts. On the

other hand, those charged with the active management of affairs require full details in order that every aspect of the situation may be understood. Only by having at hand fairly complete statistics can a manager or superintendent know exactly how things are going. His general observation and close contact with affairs may give him a general knowledge of what the financial result will be, but in order to know the exact condition and the reasons for it he must have before him the actual figures. More than that, he must have them with a reasonable degree of promptness. An accounting or statistical department which cannot meet such requirements is in need of attention.

And in passing it might be said that, as a rule, accounting departments can only do their best work or justice to themselves when close attention is paid by the superintendent and other executive officials to the reports submitted. During recent months at the New York Post-Graduate Hospital we have been greatly encouraged in this respect and now find that we are following along a pleasant pathway which tends to circle upon itself. As the management pays increasingly close attention to the reports submitted, various points are raised which enable the accounting department to prepare more satisfactory reports of the work done, and, again, as reports are improved, they increasingly command attention and consideration by the executives.

### Preparing Financial Statements

One or two observations are now in order concerning an outstanding difficulty in preparing satisfactory financial statements,—*the likelihood of errors creeping into the figures*. Inaccuracies may be due to countless reasons roughly classified as follows:

- (1) The absence of complete information or understanding by the accountants as to what is being done in the institution or hospital.
- (2) Incomplete or inaccurate reports submitted by the various departments.
- (3) Clerical errors.

Therefore, do not expect an accounting department to be infallible; rather set the standard high and expect steady improvement.

The remedy for the first condition is plain. Place someone in charge of the accounts who is thoroughly capable and in whom there is full confidence. Then outline the situation to him, so that the accounts may be intelligently examined prior to the preparation of detailed reports; tell the plans for the future, the aims and ambitions; mention some of the administrative difficulties; discuss the question of whether additional statis-

tics or reports will clarify matters. Nine out of ten times better financial reports will result. An interesting illustration along this line came to the writer's attention some time ago. The accounting department of a medium-sized hospital was reorganized, and the employee placed in charge of the office found very little from the old administration in the way of written instructions or outlines of procedures. As a result, during a period of nearly three months no charges were made for a certain special service, resulting in incorrect or distorted figures of the revenue from one department. Fortunately, when the omission was discovered (through just such a conference with an accountant as has been suggested), it was possible to go back over the ground and pick up the income amounting to nearly \$1,000 which otherwise would have been lost.

As to the other two causes of errors, it is sufficient to say that they can best be avoided by building up a spirit of cooperation between all departments. To secure the best results, considerable patience must be observed. When the necessity of changes or greater accuracy in the daily reports becomes evident, it should be remembered that time is required for the proper training of employees. Furthermore, we must keep in mind that clerical errors can never be entirely eliminated. To err may be human, but to become better and better in the handling of figures is the duty of every clerk and bookkeeper.

#### Inexpensive Systems Prove Costly

Many hospitals may hesitate to put such principles into effect and to make more than a start along the pathway of "right figures ready for reference" because of financial considerations. True, it costs money to do things properly in comparison with a convenient or easy-going method. For many years there has been a tendency in this country to reduce expenses far too much in maintaining bookkeeping, statistical, and accounting departments. Many managements even of large institutions feel that a very tight checkrein must be kept upon expenditures of this kind because the margin of receipts in excess of expenditures is either very small or non-existent. Yet experience has shown that proper steps along the lines indicated will more than pay for themselves.

To one familiar with the economies and elimination of waste possible only through controlling operations by the use of full and accurate statistical reports, this truth needs no demonstration, but another recent experience at one of the New York City hospitals may be illuminating. Expenses had outstripped the receipts and orders for rigid economy did not produce the desired

result. The superintendent asked the accounting department to analyze the situation, also that budgets of expenditures during the ensuing quarter be carefully prepared. The work involved was laborious, but most remunerative. Departmental heads were called into consultation with the chief accountant and asked to justify every cent of the anticipated expenses during the ensuing quarter. Several ways of reducing costs came to light or were suggested as the explanations or discussions proceeded, and the majority of such economies were soon put into effect without detriment to the service. But the best part of the story remains to be told. So enthusiastic did the accountant become in the task of making receipts and expenses balance that he spent quite a length of time studying the figures and then the light broke through. Two ways of increasing the revenue became apparent which, coupled with the savings or economies mentioned, solved the problem. A balanced budget is now in effect and the dangerous financial condition has been well rectified, much to the satisfaction of an anxious finance committee.

#### Importance of Up-to-Date Cost Systems

Practically all modern industrial concerns have long realized that a cost system in conjunction with the financial accounts is essential for accurate figures and proper executive management. It is strange that this fact has not been more broadly recognized among institutions for the care of the sick. The writer has read several books or treatises upon institutional accounting and has been surprised at the absence of up-to-date or scientific recommendations along this line. How many of our hospitals today can *really* tell what the cost of maintaining a semi-private patient has been for a given period? How many know the *actual* cost of maintaining a surgical ward in comparison, for instance, with a medical or babies' ward? The answer to these questions and many others of similar importance should be known as they are vital and go to the root of things. Is it not safe to say that the charges to patients should bear some relation to the cost of maintenance; and if that cost of maintenance be arrived at by an approximate method or on a guess-work basis, how can the maintenance charges be fair and just?

#### Lack of Real Cost Systems

As we go deeper into this subject we find that the absence of real cost systems has led to strange ideas in some quarters concerning the actual cost of work done in hospitals. Departments sometimes believe they are operating at a profit when



actually a real loss is being sustained. The facts are unknown because figures have not been prepared on a scientific cost basis. Instead reports have been compiled from the financial accounts which are often merely a summary of cash receipts and actual expenditures, indicating an apparent gain. But such figures are entirely misleading because no overhead expenses are included. Frequently executive officials have only the vaguest idea of what such expenses amount to and in their calculations are apt to underestimate them. The importance of this point will be grasped by reference to the annual report of any representative institution which clearly classifies the expenses. For illustration, the report of the United Hospital Fund of New York for the year 1922 shows that only thirty-seven per cent of the total expenditures of fifty-six hospitals represented the cost of maintaining revenue-producing departments. The actual figures are as follows:

	Amount	%
Professional care of patients....	\$ 3,862,183	25
Out-patient departments .....	1,819,202	12
Revenue-producing departments.	5,681,385	37
Department expenses, housekeeping, kitchen, laundry, etc. ....	5,704,109	36
House and property expenses....	2,714,541	17
Administrative expenses .....	1,134,611	7
Corporation expenses .....	406,723	3
Totals .....	\$15,641,369	100

It is evident that to secure the total or final cost of maintaining any specific department we must greatly increase the primary or departmental cost. In many instances 200 per cent should be added; in others the overhead burden runs from 100 per cent to 150 per cent. These figures may appear startling to some, but they are none the less correct, and their importance is increased when we remember that charges to patients for services rendered are often established without giving overhead expenses due consideration. Again it may be safely said that if we are to calculate profits correctly we must have at hand some reasonably accurate figures which embrace all items of expense.

### Charge for Wear and Tear on Property

Many interesting observations along this line might be made, if space permitted, and an entire chapter upon the importance of a proper cost system in hospitals and similar institutions would be most interesting. But we must confine ourselves to only one other thought because of its particular interest. This has to do with a matter

about which there may be various opinions but to which the answer is becoming increasingly clear. If we are to follow accepted principles—proved by the industrial world to be sound and true—we should include in the expenses a charge for the depreciation or wear and tear of property and equipment. Often when this principle is stated the objection is made that such amortization or depreciation is being constantly taken care of through renewals and additions made from time to time in order to keep the facilities up-to-date. By reference to annual reports for a period of years we find that this is being done and that the value of property and equipment, generally speaking, is continually increasing. But that does not alter the contention. Balancing in an incorrect or rough-and-ready fashion one outlay against another means that in effect an effort is being unconsciously made to have two wrongs equal a right. When money is spent for equipment or facilities entirely new and additional to anything previously owned, the expenditure should be charged to an asset account and should not be included in current expenses. Then each month an amount should be entered in the cost figures representing the average or fair depreciation so far as it can be calculated along scientific lines. If such a plan be followed two advantages are secured (1) the monthly expense figures become more even, and (2) the current expense figures always include a reasonable amount for what must be regarded as a real item of expense, even though it is intangible and is to be paid for at a future date.

The deeper we go into the subject, the more we become convinced that high-class, accurate and comprehensive financial records and reports lead to intelligent financial management, and that intelligent financial management leads to enduring success. The road has been opened and clearly marked for us in the industrial fields. The advantages are apparent. Well has August Heckscher, one of our leading philanthropists, remarked: "After some years of experience I have found that you bring back charitable endeavor very largely to the principles that govern efficiently managed business." Let us take advantage of what others have done and make sure that our financial records and reports to the public compare well with the best in any other sphere of endeavor.

The operation of the state hospitals last year cost the State of New York \$14,386,834, a decrease of \$1,660,182 from the previous year. The average daily number of patients cared for in the thirteen civil state hospitals was 37,936.

## THE NEW TUBERCULOSIS SANATORIUM OF CAMDEN COUNTY, N. J.

BY T. B. KIDNER, INSTITUTIONAL CONSTRUCTION ADVISORY SERVICE, NATIONAL TUBERCULOSIS ASSOCIATION, NEW YORK, N. Y.

THE plans of the general lay-out and the principal units of the new tuberculosis sanatorium, Camden County, N. J., are of interest in themselves, but it is believed that some account of the experiences of the Camden County Board of Freeholders with its sanatorium problem will also be of interest to hospital and sanatorium authorities.

Since 1914, the county has maintained a tuberculosis sanatorium at the village of Ancora, about twenty-five miles from the city of Camden, the center of population of the county. A year or so ago, it was proposed to add to the facilities of the sanatorium by the erection of an infirmary unit, and the advisory service of the National Tuberculosis Association was called upon to make a study of the existing buildings, with a view to recommending a scheme for expansion. The association submitted a detailed report, outlining a possible scheme for the remodeling of the existing buildings, and the erection of new units but, at the same time, suggested to the county authorities that they should consider very seriously the possibility of abandoning the present plant altogether, and should start anew on another site and location.

### Remodeling of Old Plant Discouraged

Several considerations led the Association to believe that it would be wiser to build elsewhere, rather than to attempt to remodel and expand the existing plant. In the first place, the location was too far from Camden, the center of population. That is often a hardship for the patients and their friends; also, it was found, as in many other similar institutions located some distance

from a center of population, that it was difficult to attract and retain good nursing and general personnel. In point of fact, the board of managers had only been able to do so by paying salaries and wages higher than other institutions in the state which are more conveniently located.

Another reason for locating a public sanatorium within easy reach of a city is that medical specialists are at all times willing to give their services in difficult or complex cases, provided that much valuable time is not consumed in traveling to and fro.

In the second place, an initial mistake was in trying, by means of various alterations and additions, to transform an old farm house into a hospital. Later, several units were added; some being inconveniently located on the site, as well as being poorly planned in their internal arrangements. The sewage disposal plant was inadequate for an enlarged institution, and was also in bad condition.

The county authorities considered the whole matter very carefully, and decided that it would be more economical in the end, and more satisfactory in every way, to abandon the existing institution and erect a modern plant nearer the city of Camden.

An excellent site was selected with the approval of the National Tuberculosis Association, and Mr. Arnold H. Moses, A.I.A., of Camden, was appointed architect; the National Tuberculosis Association being retained as consultant, acting through the present writer.

It will be noted from figure 1, that the site is oblong, necessitating a grouping of the buildings to conform to the shape of the plot.



Main building of Camden County Tuberculosis Sanatorium.



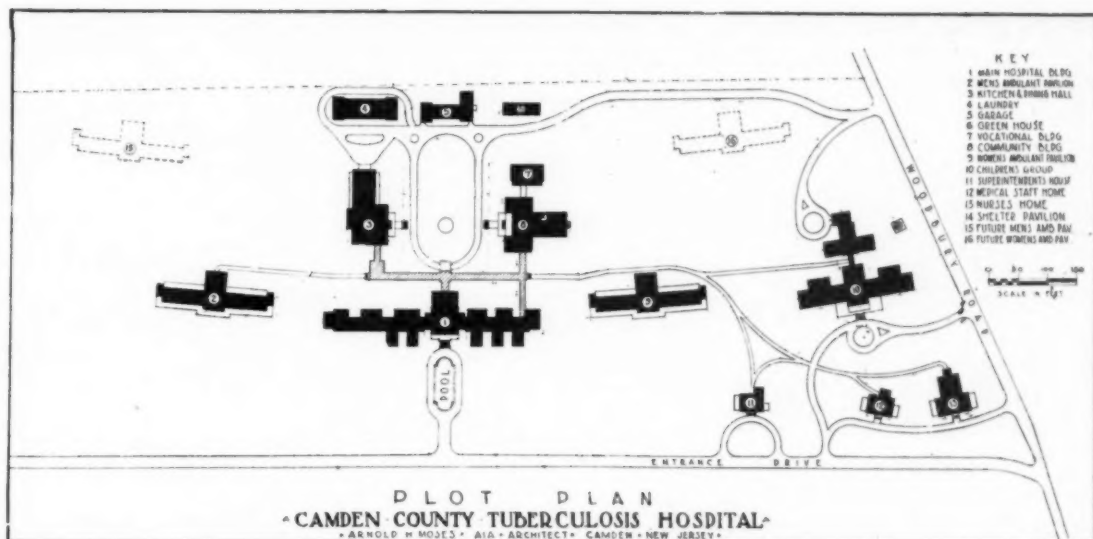


Fig. 1.

The main hospital building forms the center of the group, and is of simple but attractive design (See perspective on preceding page).

#### Buildings Arranged for Future Needs

Throughout the building scheme, future possibilities, as well as immediate necessities, have been kept in mind. For example, figures 2 and 3 show the first and second floor plans of the main hospital; one floor for men and the other for women. One-half of each floor will be devoted to infirmary cases (bed patients) and the other half to semi-ambulant patients. Provision will be made in the latter, however, for ready conversion into quarters for infirmary cases. While certain plumbing fixtures not needed for semi-ambulant patients will be omitted, the necessary piping will all be included; so that if it becomes

necessary in the future to expand the accommodation for bed patients, no structural changes will be required. This unit will have a capacity of 108 beds.

The main building is orientated to face south-east and the patient's quarters are all in the front of the building; although porches for use in very hot weather have been provided on the north side on each floor. On the first and second floors, beginning at the eastern end, four single-bed rooms, and five two-bed rooms are planned for patients acutely ill. The large window area in these rooms makes it unnecessary to provide porches for open air sleeping, but the doors of the rooms are wide enough to allow of a bed being wheeled through to the porch on the west end, or to the north porch in warm weather. The remaining accommodation for infirmary cases is in four-bed wards,



Airplane view of grounds and buildings.

with an eight-bed porch serving two wards.

Individual lights are to be installed at the head of each bed for all infirmity cases. Baseboard lights will also be provided, and a modern nurses' call system included.

The utility room is located near the one-bed and two-bed rooms, so as to minimize the travel of the nurse to and from a bedside.

Adjoining the diet kitchen is a small dining room for patients who have reached the dressing-gown stage of recovery.

### Semi-Ambulant Patients' Quarters

Passing from the infirmity section across the central portion of this unit, (to be described later) the quarters for semi-ambulant patients will be noted in the floor plans. Six four-bed wards and three eight-bed porches comprise the patients' quarters.

As befits accommodation for semi-ambulant patients, the water section is considerably larger than that provided in the infirmity section. The utility room is to be "roughed in" for plumbing fixtures, in case the whole of this unit should be needed for bed cases in the future. The room marked "vocational room" is intended for the storage of occupational therapy materials and equipment, for the use of the patients in ward occupations, or work on the porches. A comfortable sitting room has also been included.

In addition to the accommodation for patients, space for the various functions included under

general medical administration has been provided in this unit, of which it occupies the central portion. Opening from a commodious reception lobby, the business office is on the right and the medical director's office on the left of the main entrance. At the rear on this floor are located the x-ray suite, an examination room, a room for eye, ear, nose and throat treatment, the pharmacy, and the dental clinic. The x-ray suite includes a large office, to be used also for an interpretation room; the machine room; the dark room; and two dressing cubicles.

### Large Conference Rooms

On the second floor, front, is a large conference room, capable of being divided into two rooms by a folding partition; a dining room (for board members); and a small kitchen.

In the rear on this floor are located the laboratory; a room for artificial heliotherapy; and a simply equipped operating room for minor surgical procedures. (Cases requiring major operations will be moved to the city general hospital.)

On the third floor will be found open decks for sun treatment (one for each sex); a plaster room; and a small isolation section.

The basement story provides chiefly for storage, but stretcher cases admitted to the institution will be received at a rear entrance on this floor, conveniently near the elevator.

The accommodation for ambulant patients in the initial building scheme will be provided in two

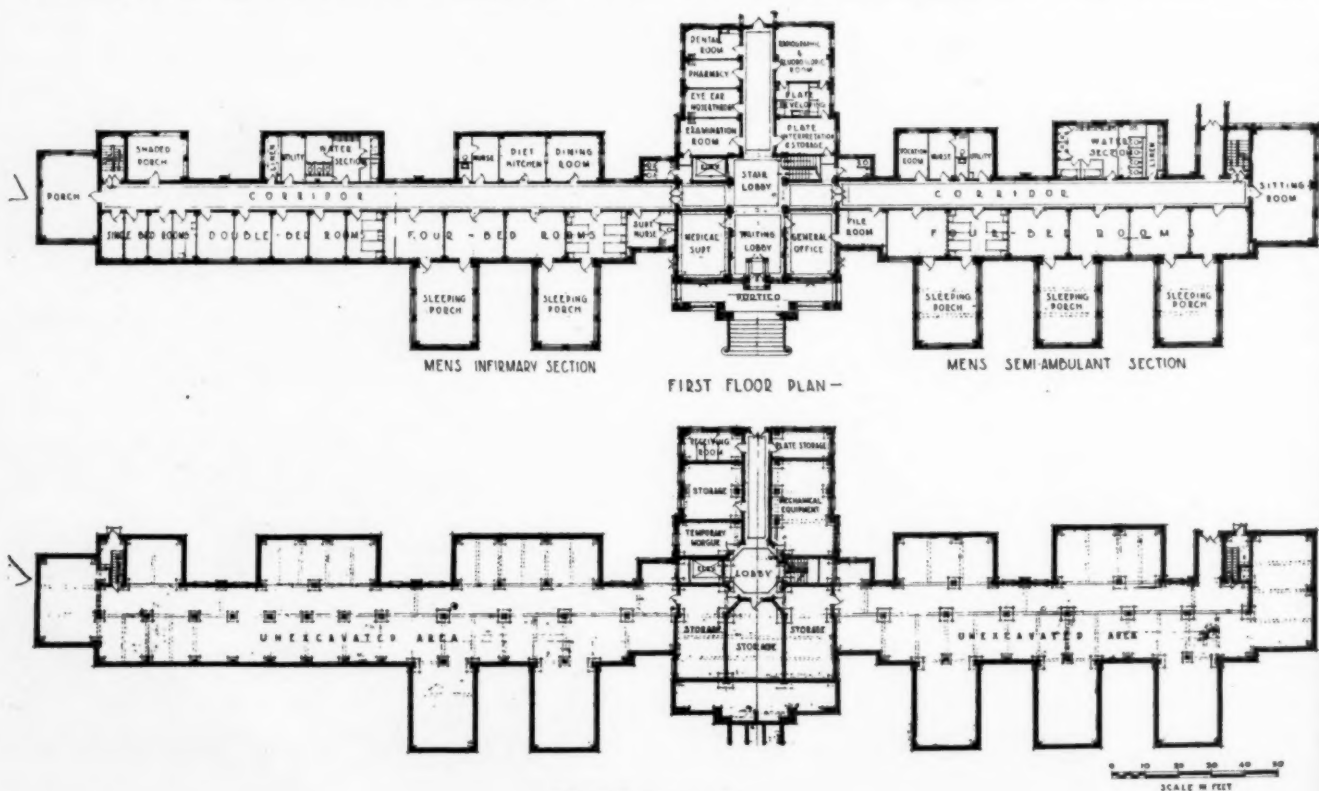


Fig. 2. Basement plan.



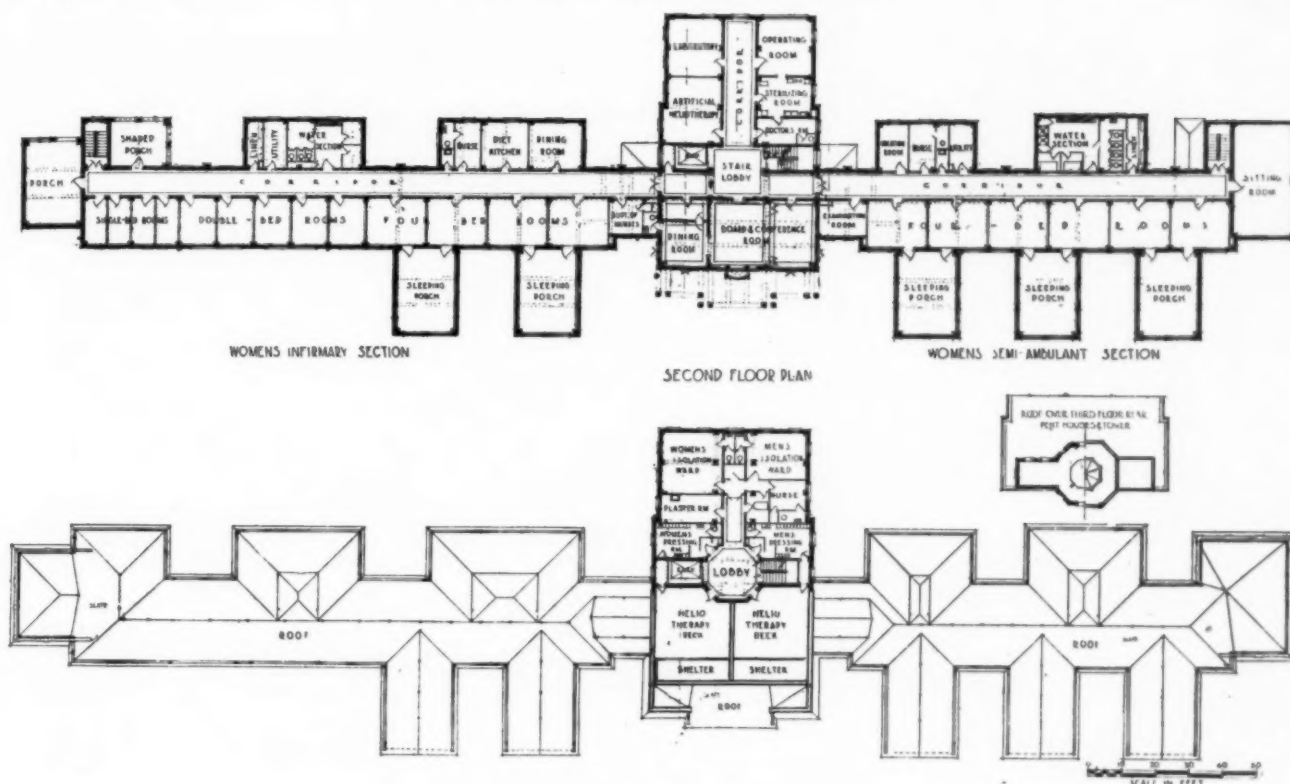


Fig. 3. Third floor plan.

24-bed, one story, pavilions; one each for men and women. (Figure 4.) A glance at the plot plan will show that these pavilions are arranged one on each side of the main unit. The plan of the pavilions is simple, but will provide comfort and a large measure of privacy for the patients. The fronts of the dormitories are glazed, but the sashes are of the side-pivoted type and will allow of being opened fully so as to form, in effect, open porches for open-air sleeping and resting.

Instead of a congregate dressing room, individual dressing cubicles will be provided in a warm corridor at the rear of the dormitories. A good-sized sitting room, with a fireplace, will add to the comfort of the patients. A terrace (at grade) on the north side, for use in very hot weather, and a similar terrace on the front, will also be very useful. Storage rooms for the "cure chairs" used on the terraces, or in the dormitories in bad weather, are provided at each end of the pavilion.

Should the institution be expanded in the future, it is intended to convert these two pavilions into quarters for semi-ambulant patients and to erect additional pavilions for ambulant patients, as shown by the dotted lines on the plot plan.

The architect has provided an interesting and attractive grouping of the various service and auxiliary buildings in the rear of the main unit. On the east side of a lawn, to

be embellished with flower beds and a fountain, is the service unit. This includes the patient's dining hall, staff dining room, kitchen, serving and store rooms; with bulk storage space below. The patients' dining room is arranged so that cafeteria or self-service can be adopted, if desired. This unit is joined to the main building by enclosed walks, and also contains a "congregating space" where patients may gather for social amenities a few minutes before meals.

On the west of the lawn, or plaza, is the auditorium, including a library and a room for quiet games. Adjoining it is the vocational building, with a well-lighted arts and crafts shop, class rooms, and storage space. Patients "on exercise" will here be given curative work and pre-vocational training.

At the rear of the lawn is a garage, with a mortuary on one end and the institution repair shops on the other. To the east of the garage

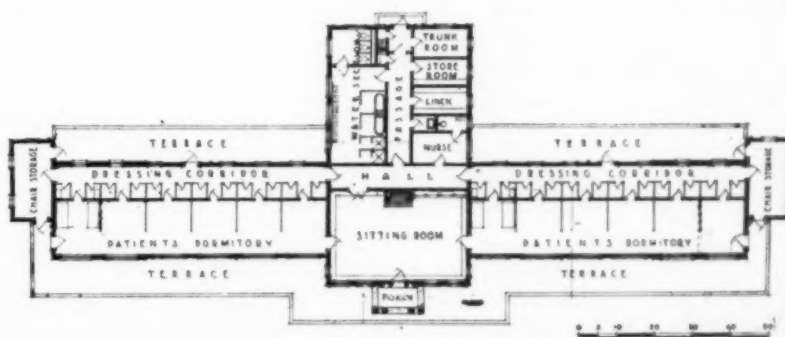


Fig. 4. First floor plan, ambulant pavilion.

unit, the laundry has been located; a greenhouse being planned to balance it on the west of the garage unit. (No heating plant has been provided, as heat is obtained from a large plant serving a group of county buildings some distance from this site.)

Figures 5 and 6 show the floor plans of the children's unit, which is planned for the reception and treatment of children suffering from tuberculosis; both with and without infective discharges. It is also intended that children of the so-called "pre-tuberculous" type shall be cared for in this unit.

### Open Decks for Sun Treatment

Open decks for sun treatment are provided; also, a room for artificial heliotherapy. An isolation section is also included in the plan.

The unit will be self-contained, and will have its own dining room and kitchen, with store rooms for daily supplies. Two class rooms will make it possible to carry on school work, and a large living room will help to make it home-like for the children.

Following the best modern practice, the children's unit is located quite away from the adult patients' quarters.

The staff quarters have also been located in accordance with modern ideas; namely, quite away from the hospital buildings proper, and near the entrance to the grounds. The staff quarters include a nurses' home, a residence for the medical director, and a building for assistant physicians.

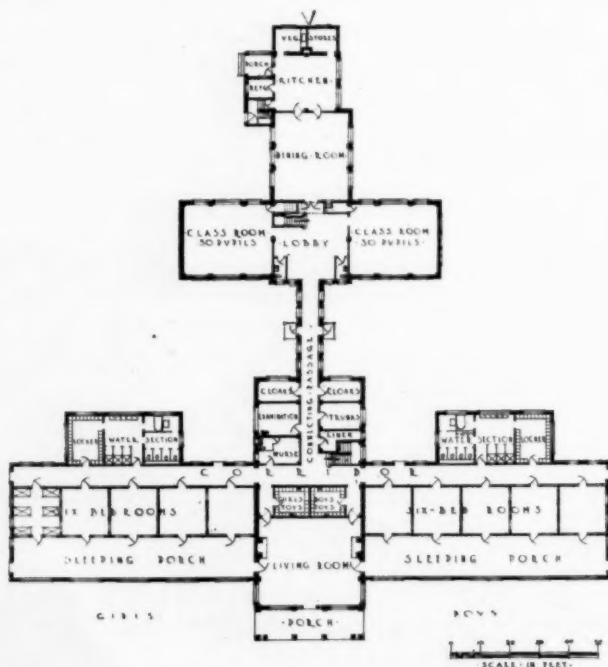


Fig. 5. First floor plan, children's group.

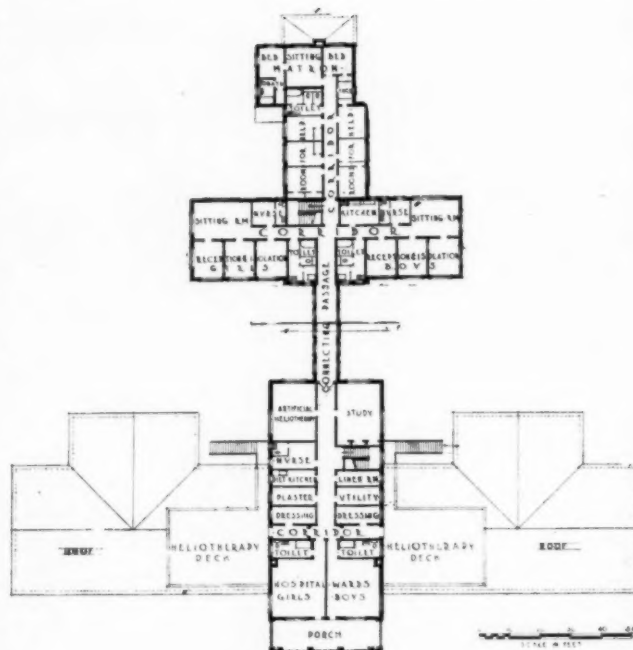


Fig. 6. Second floor plan, children's group.

### SEEING PHILADELPHIA HOSPITALS MADE EASY

When persons in search of information concerning hospitals visit a city they sometimes spend considerable time in locating the institutions where they can find the construction, organization or administrative features which they wish to see in use, or to study some special feature of hospital work, which may have been particularly well developed in a certain institution.

To meet this need the Philadelphia Hospital Association has a special committee at work securing and tabulating the worthwhile features of the institutions in Philadelphia and vicinity. This information when secured will be arranged so that a visitor to Philadelphia may communicate with the secretary of the Philadelphia Hospital Association, or with members of the association, who will advise the visitor what institutions to visit to obtain the information concerning their particular problem.

The hospitals of Philadelphia have cooperated heartily with this plan to make information concerning the hospitals of the city readily available for institutional people from other places.

### AWAITING NEW RADIO DEVELOPMENTS

We have heard of several new hospital projects that planned to install radios in the rooms. When we have enquired as to the type of installation none has given a satisfactory answer, for all await new developments in radio. The last person we interviewed said he had abandoned the idea, because he believed that within five years the pocket radio will be so developed that no provision need be made by hospitals and hotels. Radio, he said, is unlike any other force. It is not barred by anything; it passes through walls, and the radio set, independent of plugs or wires, taps the atmosphere anywhere.

The Charity Hospital, New Orleans, La., has opened a special hay fever clinic which is being conducted under the supervision of Dr. William Scheppegegrell, president, American Hay Fever Prevention Association.



## A STUDY OF BUDGETS FOR SCHOOLS OF NURSING\*

BY ELIZABETH A. GREENER, CHAIRMAN, COMMITTEE ON BUDGETS IN SCHOOLS OF NURSING, NATIONAL LEAGUE OF NURSING EDUCATION; DIRECTOR, SCHOOL OF NURSING, MOUNT SINAI HOSPITAL, NEW YORK, N. Y.

**F**OLLOWING the June, 1923, meeting of the National League of Nursing Education at Swampscott, Mass., a special committee was appointed by the executive board of the league to make a study of the subject of nursing school budgets and ascertain, if possible, to what extent the budget system is being followed in our schools, and to develop some basic figures to be used in estimating the actual present cost of maintaining nursing departments. This action was prompted by the paper on the principle underlying budget-keeping presented by Prof. Charles F. Rittenhouse, Boston University, Boston, Mass., who urged the adoption of budgets in schools of nursing.

The committee consists of the following members: the Misses Lillian Clayton, Louise Powell, Amy Hillard, Sally Johnson, Helen MacMillan, Ada Belle McCleery, Mary L. Keith, Mary C. Wheeler, and Laura R. Logan (ex officio), with the writer as chairman.

In preparing for the study, it was found that there was little available material on the matter that could be considered helpful to our group. A budget form was prepared by the committee following closely the plan suggested by Prof. Rittenhouse and submitted to him for approval and for further suggestion. As a result, on May 12, this committee sent out to eighty schools from all parts of the country, a questionnaire, a blank budget form, and a form letter urging co-operation on the part of schools of nursing and hospitals by returning either their own annual statement of estimated income and expenditure or the submitted budget form, properly filled in with such figures.

The schools of nursing selected represented various types from the largest to the smallest; from the university school to the small school connected with the isolated community hospital. Replies were received from fifty-two of the eighty schools. In most cases the questionnaire only was answered, and the budget form ignored or returned. Twenty-eight schools made no reply. Only six schools returned budgets in such form that they could be used for this comparative study, although certain isolated figures from eight other schools were used in the composite statement formulated by the committee. Several schools submitted their own annual statements or partial statements, but in most cases the

superintendents of schools of nursing, and in several cases the heads of hospitals, wrote to say that it was impossible for them to separate the expense accounts of the hospital from those of the training school.

The result of the questionnaire sent out was as follows:

- Question 1 "In the administration of your school nursing do you prepare a budget of income and expense?"  
8 schools replied "yes"  
44 schools replied "no"
- Question 2 "If so, who is responsible for the preparation of the budget?"  
4 schools replied "supt. of hospital"  
2 schools replied "supt. of nurses"  
46 schools, no answer.
- Question 3 "Can you supply the committee with the copy of your budget showing a definite schedule of income and expense items?"  
(20 estimates received in all)  
6 schools returned complete budgets  
14 schools returned partially complete budgets
- Question 4 "What method of bookkeeping is used in your school?"  
12 schools replied "double entry"  
40 schools, no answer
- Question 5 "How frequently are statements of income and expense prepared?"  
8 schools replied "annually"  
2 schools replied "semi-annually"  
42 schools, no answer
- Question 6 "Do these records show actual budget figures in comparative form?"  
49 schools, no answer  
3 schools replied "yess"
- Question 7 "When does the fiscal year end?"  
35 schools replied "December 31st"  
3 schools replied "March 31st"  
12 schools, no answer
- Question 8 "If a form budget for your school has never been prepared would you welcome assistance in placing your financial affairs upon a budget basis?"  
35 schools replied "yes"  
6 schools replied "no"  
5 schools, no answer  
Eight schools stated that their hospitals were considering the installation of a separate training school budget during the coming year.

Replying to the last question as to whether the school would welcome assistance in placing training school affairs on a separate budget basis, one canny soul replied that before accepting assistance she would deem it wise to find out what might be involved by so doing. Another stated

\*Report of the committee on budgets in schools of nursing, National League of Nursing Education, of which Miss Greener is chairman.

that she herself would have to have a much greater knowledge concerning budgets than she possessed at the present time before she would dare reply to such a question.

### Involved with Hospital Accounts

As a result of these returns, it was ascertained that in many cases the hospital itself was not administered on the budget plan. In nearly every letter received the fact was stressed that training school accounts were so hopelessly involved with those of the hospital that any separate financial study was an utter impossibility. Many who attempted to use the budget form presented for their use by the committee gave it up as an impossibility when they found how much work would be involved in making such a study and how subject to question many such figures might prove to be.

On the whole, there seems to be a general desire on the part of both hospital and training school authorities to establish a system which will enable them to determine the actual cost of the nursing department to the hospital.

As Professor Rittenhouse carefully explained last year, budget making is simply financial planning based on a careful estimate of expected income as compared with intended or expected expenditures. It is the only method by which an actual comparison of expenses becomes possible and is the best possible method for the control of expenditures. An initial budget is always most difficult of preparation and should be reviewed and studied by an experienced finance committee. In most cases the development of an initial budget for a school of nursing would necessitate a study which should extend back over a number of years if it were to be accurate or definite. The adoption of the separate budget system would, without doubt, call for an increase in the hospital or training school clerical force.

A vital step in the budget making is the accurate and appropriate placing of each item of expenditure. Even in this limited study with identically the same budget form there was a great difference in the interpretation of various items by the different schools.

### The Need for Budgets

Because of the many difficulties which the committee found in connection with this study, it can only be termed an approach to budget making through a preliminary analysis of the expenditures of schools of nursing. Two questions naturally present themselves as one studies all the vexing problems in connection with such a plan: first, is it possible at this time to establish a system of

cost accounting in the schools of nursing in this country; and second, is such a system *desirable*? So far as the hospital itself is concerned, these questions seem to be answered by Dr. Malcolm T. MacEachern, president of the American Hospital Association and director of the hospital activities of the American College of Surgeons, who, in a recently published paper, states, "Budgets should be maintained for *all* departments, worked out on a definite business cost for service to be rendered, and based on past experiences that are reliable for comparison." In further support of this argument attention is called to the fact that the American Hospital Association, realizing the timeliness and importance of this subject, recently appointed a special committee on budgets to report at its next annual meeting.

At the meeting of the American Hospital Association last year, Dr. Caroline Hedger pertinently asked, "How can health or conservation of nurses be considered or even discussed until we know what it costs to replace a student nurse when she is ill and what illness and resignation among student nurses cost the hospital."

The following figures presented by the committee regarding their findings are based on estimates furnished by six representative schools, one from California, one from Illinois, one from Massachusetts, and three from New York. Certain isolated figures which it has been possible to select and use from the financial statements presented by eight other schools have also been used. Almost without exception schools of nursing have no separate or independent funds and no income of any importance outside of the estimated earnings of student nurses. In a few instances a small amount is collected annually in the form of registration fees charged to students or from the sale of books, uniforms, instruments, etc., to students. Such articles, however, have to be purchased by the school originally and are generally sold at cost. The matter of income, therefore, was not one which called for any particular study except as to the amount that should be charged to the hospital for the nursing service of students. This can better be determined at the end than at the beginning of our study.

The total composite budget as developed by this committee will first be presented and then analyzed. The figures quoted are the per capita charges against each nurse per year.

- Item 1 relates to the physical maintenance of the buildings dealing with upkeep, repairs, and replacements.
- Item 2 deals with the physical operation of the nurses home and allied buildings and covers the cost of light, heat, power, wages and supplies. It has been necessary to combine



item 1 and 2 because of the different interpretations made by the hospitals submitting figures .....	\$101.28
Item 3 includes all fixed charges such as interest on hospital invested funds, rent, taxes, insurance (fire or liability) and estimate as to depreciation of buildings.....	197.68
Item 4—Administration or Operation:	
(a) Salaries of officials to be charged to school .....	120.01
(b) Maintenance charge where due.....	37.63
(c) Domestic salaries .....	38.90
(d) Domestic's maintenance .....	32.63
(e) Charge for time of hospital officials..	9.38
(f) Educational supplies .....	4.77
(g) Special expenses: students' uniforms, textbooks, etc. ....	63.10
(h) Commencement expenses .....	5.88
(i) Students' allowance .....	133.00
(j) Charge for sickness .....	51.83
(k) Recreational .....	7.59
(l) Linen: bed and table .....	11.82
(m) Mattresses and pillows: renovation, etc. ....	1.20
(n) Dishes and silver .....	3.71
(o) Furniture and furnishings .....	15.63
(p) Food, including all overhead charges..	367.47
(q) Laundry .....	67.65
Item 5—Office expense .....	5.46
Item 6—Telephone and telegraph.....	2.50
Item 7—Advertising expense: publicity and auditing, etc. ....	3.09
Item 8—Miscellaneous .....	2.92
Grand total (all expenditures) .....	\$1,285.13

Our analysis necessitates the tentative acceptance, at least, of certain basic building and administrative standards. For instance, in considering item 1 (that of physical maintenance) and item 2 (physical operation) we start by estimating at least 4,000 cubic feet for each nurse. As some of the new nurses' homes require fully 4,500 cubic feet per occupant, 4,000 cubic feet is a conservative figure for a home in which the basic unit is a single (not a double) room. In building, it is customary to estimate hospital nursing needs at the rate of one nurse to every two patients, though in a few instances, hospitals are actually providing three or more nurses for five patients.

In estimating total hospital requirements for one patient, 12,000 cubic feet of space is considered the necessary quota, which figure includes the 2,000 cubic feet representing the individual pupil's share in the nurses' home, a share which is equal to one-half of space for each nurse. If 2,000 of the required 12,000 cubic feet per patient or one-sixth of the required hospital space is needed for the school of nursing, then one-sixth of all building or building maintenance cost should be charged to the nursing department.

In estimating item three, fixed charges, we

again take our required 4,000 feet of space which, estimated at a cost of eighty cents per cubic foot for multiple-storied, fireproof buildings of the most approved type of construction and finish, (today's building figures) plus proportionate land values and furniture for nurses' home, give us a figure approximating \$4,000 as the capital investment required for the housing of each nurse. If this figure seems a little high, it must be borne in mind that 4,000 cubic feet is probably less than today's actual requirement in building nurses' homes.

Estimating the capital invested by the hospital for the nursing department at the rate of \$4,000 per nurse, a five per cent interest return on that amount furnishes a figure of \$200 to be charged off against each nurse per year. In our composite budget in one instance, the interest charge was only \$41 per pupil which would indicate that the hospital submitting this figure estimated its capital investment for each nurse at \$850 in place of the \$4,000 which would probably be required today for building a nurses' home. The figure of \$850 undoubtedly represents the cost (many years ago) of a non-fireproof home of a type no longer acceptable as either safe or desirable. The composite budget yields the figure of \$142.25 per nurse as the item of interest or a total cost for building and grounds of \$2,845.

In schools where interest is charged, there will probably be no rent item and most hospitals are tax exempt. Tax exemption represents a community contribution which does not appear at all in our study. Insurance (fire) is quoted at varying rates according to the type of building insured. One school with first class fire-proof buildings quotes a rate of seven cents per hundred. Liability insurance varies from thirty to forty cents per hundred.

The charge as to the depreciation of buildings is generally computed at a two or three per cent rate in well-built, fireproof construction which would allow for renewal or abandonment of the plant in from thirty-three to fifty years.

Item 4—administration or operation, which is divided into many subheads, presents points for discussion which are less involved and about which the average training school superintendent feels herself to be reasonably well informed. Under subheads (a) and (b), the entire salaries and maintenance of the teaching or special officials, who give full time to the student nurses, should be charged off against the school of nursing; also a fair proportion of the time and maintenance of all other nurse officials. It has been estimated that three-fourths of the superintendent's salary and maintenance might be charged, one-half of

the assistant superintendent's and from one-eighth to one-third of certain supervisors and head nurses who have definite teaching duties.

The same facts hold good with servants whose duties are limited to the nurses' home and who deal entirely with the nursing group. Their salaries and a fair maintenance should be charged off as a part of the nursing expense. The maintenance figure for this group has been estimated at rates varying from \$365 to \$500.

It has been surprising to find that some schools make no charge against the department of nursing for time spent by hospital officials other than nurses. In several instances, the statement was made that no time was spent by hospital officials on training school matters and yet in the next breath we were told that all training school accounts were so tied up with the hospital accounts that a complete budget could not be returned. Undoubtedly in almost every school of nursing most of the bookkeeping (except possibly the actual making out of the monthly payroll) and all handling of special funds are done through hospital executives. It is only fair to assume that time spent by the head of the hospital in advising with training school authorities as to the various nursing problems should be considered as well as that of other officials, bookkeepers, clerks, etc.

Probably all other subheads under item 4 are self-explanatory and call for no particular argument. Considerable difference was found in the estimate made for furniture and furnishings, dishes, bed and table linen. Undoubtedly such figures will vary greatly according to policy of the hospital in providing generously or frugally for the needs of the nurse. The item of food was one concerning which there was less difference proportionately than any other. Ten schools reported on this item. The lowest estimate was \$266 per nurse, the highest \$547.50. In the matter of laundry expense there was also a marked variation. Quotations were received from eleven schools, the lowest of which was \$18.72 per year per pupil, and the highest \$143. It was interesting to note that in each of the cases quoted, the school stated positively that there was no doubt as to the accuracy of that figure. The composite total of \$67.65 will probably be considered as a fair average estimate.

#### Budget Separate for the Two Groups

After totalling the composite budget as a whole it was again subdivided in order to make clear just which items were chargeable to all nurses and which items must be charged to student nurses for educational or special purposes. This

was done in order that a financial comparison might be made between the two groups.

BUDGET FOR DEPARTMENT OF NURSING

Chargeable to All Nurses	Per Capita	Schools Reported	For Students Only Educational and Special	Per Capita	Schools Reported
Item 1—Maintenance of buildings with repairs or replacements	\$101.28	6			
Item 2—Physical operation—light, heat, power, etc., wages and supplies					
Item 3—Fixed charges—Interest, insurance, depreciation of buildings	197.68	5			
Item 4—Administration or operation			Item 4—Administration		
c—Domestic salaries or wages	38.90	5	a—Salaries of officials doing educational or special work	128.01	6
d—Domestic maintenance	32.65	2	b—Maintenance charge of this group	97.83	3
e—Charge for Hospital officials' time (1% total)	4.89	5	e—Charge for Hospital officials' time (1% total)	4.89	5
f—Linens, bed and table	11.82	6	f—Educational supplies	4.77	6
g—Mattresses and pillows, renovation, etc.	1.20	5	g—Special cost of uniforms, text books, etc.	63.10	4
h—Dishes and silver	3.71	6	h—Commencement exercises	6.86	5
i—Furniture and furnishings	15.63	7	i—Students' allowance	133.00	3
j—Food, including overhead charges	367.47	10	j—Charge for sickness	51.83	5
k—Laundry, including overhead charges	67.65	11	k—Recreational	7.58	6
Item 5—Office expense (1% total)	1.82	6	Item 5—Office expense (1% total)	3.54	6
Item 6—Telegraph and telephone	2.50	6	Item 7—Advertising, publicity, etc.	3.09	4
Item 8—Miscellaneous	3.92	5			
(No estimate for sickness)					
(No estimate for vacation relief)					
For graduate maintenance, total	\$849.90		For educational and special purposes	435.25	
For graduate salary at \$80 per month	960.00		For maintenance	849.90	
Total cost	\$1,809.90		Annual per capita, Grand Total	\$1,285.15	

A study of the composite budget as a whole yields the following interesting figures: Of the total \$1,285.00, \$850.00 is the actual maintenance charge to be made for all nurses, either graduate or student. The remaining \$435.00 is the amount chargeable to nursing education and special student nurse expense. The total cost of the single graduate is \$850 maintenance, plus her salary per year of \$960 or \$1,810. The cost of the student is \$850 for maintenance plus \$435 for education or \$1,285 total. One might be tempted to jump quickly to the conclusion that if the student costs the hospital at a rate of \$1,285 while the graduate costs \$1,810 per year, inclusive of salary, the cost of the graduate group would be much greater, but such is not really the case.

#### Cost of Student Nurse Higher

As a fact, the expense to the hospital is relatively greater through the use of the student group because of a direct loss in three different ways: first, through the loss to the hospital involved in carrying the entire probationary group as extras. In a school with a daily average of 100 pupils we would expect to graduate a class of at least thirty per year. It is generally conceded that from twenty-five per cent to forty per cent of the students leave during training. Taking



the lowest figure of twenty-five per cent in the 100-student school, at least forty probationers would have to be admitted each year and be carried for a period of four months, or one-third of the year, in order to keep up the ranks of the school which would signify that the hospital is carrying an average daily loss of thirteen per cent of all nurses. In many schools fifteen per cent to twenty per cent estimated loss would be nearer the actual figure. The second loss which occurs to the hospital is a time loss. Student nurses are on the wards eight hours, graduates, nine hours. The relative loss through the use of the student nurse group, therefore, would be one-ninth of the whole amount or practically eleven per cent. The third loss occurs because of the lack of experience or efficiency of the student nurse group.

A generous estimate of the relative value of the student as compared with the graduate would be that in her first year (exclusive of probation) she might be said to represent seventy-five per cent of the graduate's value, in her second year, ninety per cent; and in her third year ninety-eight per cent or a general average of eighty-eight per cent efficiency during her entire training as compared with the graduate. Thus the total loss to the hospital is thirteen per cent through probationers, eleven per cent through shorter hours and time loss, twelve per cent through lack of efficiency, making a total relative loss, as compared with the graduate group, of thirty-six per cent or a relative efficiency of sixty-four per cent on the part of the student group, 100 per cent representing the full value of a graduate nurse. If the graduate group costs the hospital at the rate of \$1,810 each per year, the relative value of the student nurse rated at sixty-four per cent of that amount would be \$1,158.40. Since the cost to the hospital of the student is \$1,285.13 and her estimated value amounts to \$1,158.40, the total loss to the hospital through maintaining a school of nursing amounts to \$126.73 per student each year. If the school is maintaining less than a three-year course, the loss to the hospital would be proportionately greater, as more students would have to be enrolled and a larger group of probationers maintained, besides which the relative value of the senior students would have to be scaled down below ninety-eight per cent. Hospitals that maintain the full three-year course of training receive, therefore, the best financial return from their schools of nursing.

Another interesting figure is that of the cost of the student to the hospital per working hour. This is a figure which has been very much discussed at different times during the past three years. The student works, according to the findings of the committee: thirty-six weeks, first year

(sixteen weeks probation deducted); forty-eight weeks, second year (one month vacation deducted); and forty-eight weeks, third year, (one month vacation deducted) which gives us a total of 132 weeks in three years' course.

If the fifty-four hour week is maintained (which allows for the eight-hour day minus extra time on half days, holidays, Sundays, and days following night duty) 7,128 hours in all is the amount of time the student works. The cost of the student nurse to the hospital for entire training is \$1,285.13 multiplied by 3 or \$3,855.39. This sum divided by 7,128 hours equals fifty-four cents per hour cost to hospital (all maintenance and educational items included) and in turn equals \$4.32 per day or \$130.40 per month.

The financial comparison which our composite budget permits us to draw between the graduate nurse and the student nurse group would seem to be a decided argument in favor of the employment of the graduate nurse group: first, because of her greater earning value through greater experience; second, her longer hours of duty; third, because in a hospital staffed with graduates only the nursing could be done with at least as many less nurses as the daily average of its probationary class. It must also be granted that less supervision is required by this group owing to greater familiarity on the part of the graduate with her work and much less time loss through illness than is the case with the young student nurse, who has not yet become adjusted to the physical demands of her nursing work. Another point in favor of the graduate nurse group is that a hospital staffed with graduates could easily develop a group of attendants to take over a large part of the routine nursing work now done by student nurses, which would further tend to reduce the expense of conducting the nursing service of the hospital. The last three arguments, however, have not been considered in this financial study, but there are vital factors that cannot be indicated in merely a financial study.

The arguments against the use of the graduate nurse group in the hospital for general duty are that the individual nurse too often lacks interest or inspiration and that the group as a whole lacks permanence or stability. As a result the rapid turnover makes it exceedingly difficult to maintain standardized nursing technique in any hospital acquiring graduate nurses in large numbers because of the variety of nursing methods thus introduced.

The greatest arguments in favor of the use of the student nurse, in spite of her apparent greater cost to the hospital, are that, because of her youth and buoyancy and the fact that she is receiving a nursing education in which she is deeply

interested, she brings an atmosphere of inspiration, of initiative and of human cheer to the place that could never be developed in any other way. Student nurses are constantly on the alert for information, knowledge and experience and keep everyone around them stimulated educationally. Since they are a younger and more flexible group, they respond readily to suggestion and necessary restriction.

Superintendents of experience justly claim that the student's value to the hospital in the third year of her training is so great that, if given the choice, they would invariably select her in preference to a graduate nurse for general duty. Our final and most important consideration in developing this comparison between the two groups, is the fact that the hospital with proper standards has a return duty to the community which supports it that it must meet by educating and preparing student nurses not only for all hospital nursing needs but for those also of the community at large. If schools of nursing were abandoned, we should risk return to the Sairy Gamp condition in hospitals, and welfare work in communities might be brought to a disastrous and sudden termination.

In considering the result of this necessarily limited study, the committee wishes to stress the surprising per capita differences existing in the figures presented by different schools. The totals of the six budgets, on which the larger part of the study was based, ranged from \$718 to \$1,410. This wide range was due to several causes. In some cases no monthly allowance was paid students while in one instance students received an allowance of \$20 per month. Only one school submitted a complete estimate with every item considered. The study has also demonstrated the totally different standards existing in different hospitals regarding training school requirements as to instruction, educational equipment, scholarships, recreational funds, etc.

The results, however, show quite conclusively that in hospitals where an adequate nursing education is maintained—where the eight-hour day prevails and where students are suitably housed and cared for, the time has passed for accusing the hospital of exploitation. Today certain hospitals are maintaining educational institutions in the form of their schools of nursing at considerable cost to themselves, which cost is constantly mounting. There is, among them, no complaint because of this increase in cost and responsibility, but rather in each case an intense pride in the school as an educational factor productive of good not only to themselves but also to the public whom they serve so well. And, unfortunately, the

charge of exploitation still holds against many hospitals whose standards are grievously low.

The committee would respectfully recommend that the National League of Nursing Education strongly urge hospital and training school authorities to unite efforts in bringing about the general adoption of a separate budgetary system for schools of nursing throughout the country for the following reasons:

(1) In order to do justice to hospitals maintaining proper standards in their schools of nursing and to free them from the charge so frequently brought of exploitation of student nurses.

(2) In order to enable hospital authorities to make application for a separate and extra proportion of funds assigned them through community chests, federations, etc., to be devoted to the exclusive use of the school of nursing.

(3) In order to place definitely before the public the need of greater financial support and assistance in properly housing and educating student nurses.

During the past ten years the whole hospital system has undergone a complete change; medical education also has changed radically and increased greatly in cost. Should it surprise us to discover that nursing education has changed greatly both as to method and cost?

Until the separate budget system for schools of nursing is adopted, definite comparisons cannot be drawn nor can financial expenditures be planned intelligently and economically in advance in order that ugly and unexpected deficits may be avoided.

Your committee is of the opinion that if the nursing needs of the hospital and the educational needs of the school of nursing are to be fairly and adequately met—if the health and happiness of the young student nurse is to be properly considered and maintained, hospital authorities and nursing heads should be in a position where they can estimate correctly and intelligently the total cost of such service in each of its varied requirements.

In the Rockefeller Report of 1923 were many recommendations for the correction of existing limitations and evils in schools of nursing, one of its foremost was that the community be brought to understand that if nursing education adequate for the care of the sick and to meet the need of modern health campaigns was to be properly developed, the securing of endowment funds for such purpose must be considered as an absolute prerequisite. It is difficult to see how the sums required for endowment funds for schools of nursing can be estimated until each hospital and school can present a definite and correct account



of its practice and expenditures. The difficulty experienced by practically every hospital and school approached is felt by the committee to be one of the strongest arguments that can be produced in favor of a separate budget for the school of nursing.

In closing the report the committee wishes to

express its gratitude and appreciation to the schools furnishing the budgets or various estimates on which this report was based. Special thanks are due Prof. Charles Rittenhouse and Dr. S. S. Goldwater without whose helpful assistance this study would have been almost impossible.

## PSYCHOPATHIC WARDS OF THE BUFFALO CITY HOSPITAL\*

BY SAMUEL W. HAMILTON, M.D., NATIONAL COMMITTEE FOR MENTAL HYGIENE, NEW YORK, N. Y.

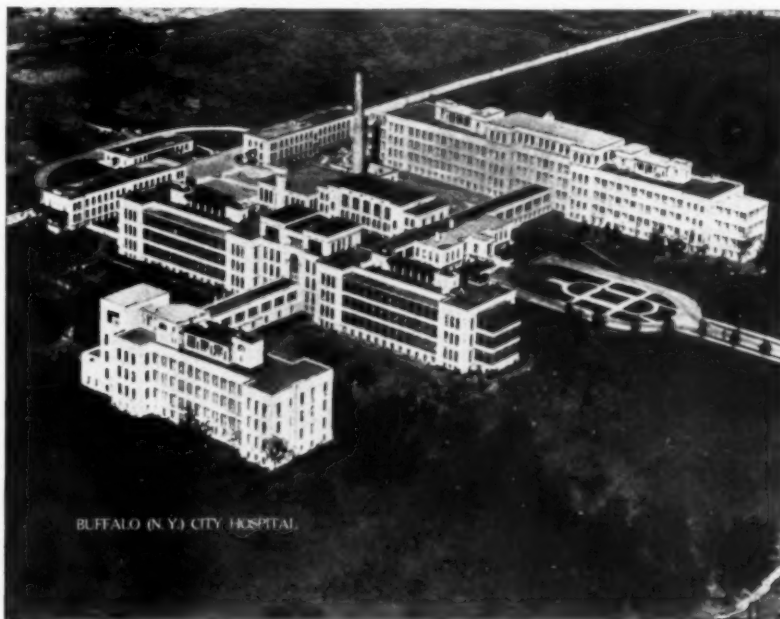
FOR several decades a few of the largest public hospitals in our large cities maintained wards to which were assigned patients suffering from some mental disorder. In days when nursing personnel was small and nursing standards low, these wards were very much like prisons, free, to be sure, from dungeons and noisome corners but with high, heavily barred windows and strong barred doors.

As the demand for better nursing asserted itself, the time came when some of these older wards were replaced by new ones, carefully constructed, but less somber and quite free from the extremely disagreeable and humiliating likeness to prison cells. In the present century the psychopathic hospital, so-called, developed in this country as a small hospital given over entirely to problems of mental illness, and several such institutions now exist.

Except in the largest cities, and sometimes even there, the most desirable arrangement is to have one or more wards for the mentally ill as integral parts of a general hospital. When funds are available to build as one wants to, a separate pavilion is usually erected, placed at a point where a noisy patient can be allowed to express himself

freely without disturbing patients in other pavilions. It may be remarked that sometimes the noisiest patients are those in the obstetrical and children's wards, rather than in the psychopathic pavilion. The first important building on these lines was pavilion F of the Albany City Hospital, Albany, N. Y., opened in 1902 as a result of the

initiative and energy of the late Dr. J. Montgomery Mosher. Another is the psychopathic pavilion of Kings County Hospital, Brooklyn, N. Y. To mention only a few psychopathic wards located within buildings which provide also for other types of patients, one may point to Bellevue Hospital in New York, Philadelphia and Cincinnati General



General view of Buffalo City Hospital and grounds, Buffalo, N. Y.

Hospitals, Cleveland City Hospital, and Louisville Public Hospital.

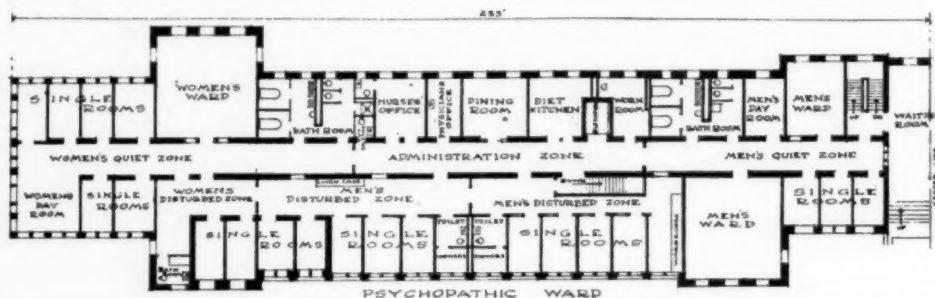
The Buffalo City Hospital has recently built on a site well toward the margin of the city a new structure to care for several distinct types of patients. The pavilions project in both directions from a long central corridor. In one of these three-story pavilions the ground floor is given over to the care of mental patients brought to the hospital for observation pending the determination of the legal question of sanity and removal to an institution where more prolonged treatment can be given. Not only is this building new but it has been carefully planned and is worth the

\*The writer acknowledges the courtesies extended during this study by Dr. Walter S. Goodale, superintendent of the Buffalo City Hospital; Dr. Herman G. Matzinger, professor of psychiatry of the University of Buffalo; and Mr. Thomas B. Kidner, of the National Tuberculosis Association, for advice and assistance.

consideration of any one who has a similar problem to meet, the proper housing of a rapidly changing group of persons, most of whom are mentally ill and all of whom are under observation for that reason.

The building is a steel frame structure, brick faced, a very fair idea of which is given by one of the accompanying pictures. In this picture the

be briefly discussed before describing the layout in more detail. In the center is the administration zone, which is a service section for the whole ward. Here are the nurses' and physicians' offices, a dining room for ambulant patients, a diet kitchen, utility room and elevator. Owing to the strategic placing of this zone, it is possible to step from it through a door into the section for



pavilion which houses the psychopathic ward is the one farthest to the right and, as previously mentioned, the ground floor is assigned to these cases. It will be noted that somewhat obtrusive bars have been placed outside the windows, rather than a more ornamental and less offensive grill. In these surroundings, however, any type of bar is less noticeable and therefore less objectionable than would be the case in an isolated pavilion.

The floor plan is oriented as shown in the illustration. The central corridor will be noted at one end of the psychopathic ward. The building extends forward as well as back from this point but the forward wing is not occupied by mental patients. The psychopathic pavilion has a corridor which does not open directly into the connecting corridor with the rest of the hospital, but has a large fixed window at that point. The entrance, as will be noted, is through the stair well.

The reader will note on the floor plan that the pavilion is divided into several zones, which may

the quiet patients of either sex, and into two of the three disturbed sections. In practice it has been found unnecessary to close the doors between the administration zone and the men's and women's quiet zones. They are practically wide open at all times, so that the view down the corridor is made much more pleasant. It may be remarked that this corridor is less shaded than many, because the nurse's office and diet kitchen have no doors, thereby permitting more light to pass, and at the far end the corridor widens out into the women's day room, an arrangement which also makes for brightness. The physician's office is well placed almost in the center of the ward. Too often the physician is located at some distance from the points of greatest activity and therefore has difficulty in knowing exactly what is happening among his patients.

At the ends of this main corridor are the sections for quiet men and quiet women. It will be noted that in each of these sections there is a dor-

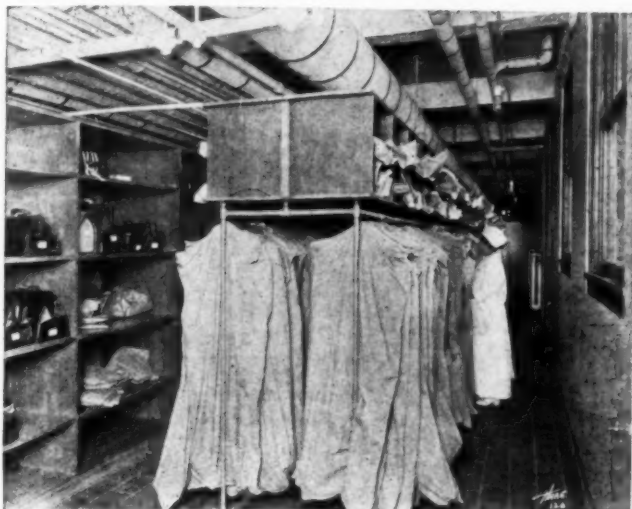


Well-lighted connecting corridor.



Small psychopathic ward.





Clothing room in basement.

mitory accommodating conveniently about eight beds, and several smaller rooms. The water section is well arranged with tubs and washstands at one side, and toilets on the other side of a partition which encloses a pipe chamber.

### Three Zones for Disturbed Patients

There are three zones set aside for disturbed patients, so placed that usually men occupy two of them, but, if needed, two may be used by women. In these zones there are only single rooms, all opening off a corridor which parallels the main corridor of the ward. It will be noted that for each sex there are two rooms which have extra thick walls planned to be sound proof; these rooms also have double doors. Their windows are not guarded on the inside so that a patient need not feel himself more strictly immured in one of them than in any room in the ward. Each of these disturbed zones has its own single toilet and bath. There are fixed sashes in the walls of these rooms, excepting the special sound-proof rooms, so that light will shine through into the corridor. This corridor can therefore be used as a sitting room and on the occasion of the examiner's visit was so used by a police officer who was there able to read in full view of his prisoner, a patient in one of the single rooms.

### Hydrotherapy Apparatus in Basement

For disturbed patients, the prolonged bath is an important therapeutic measure. Four bath tubs have been installed in the basement which can be reached quickly by the stairway leading out of the disturbed men's zone. The stairs are of marble and without a handrail. Various other functions are carried on in the basement, such as the care of all the patients' clothing, the reception of new patients and the out-patient work of

the hospital. Obviously it is not feasible to make so much use of these basement tubs as would be desirable. Perhaps at some future time one or two tubs will be installed on the floor where the patients are quartered.

Most of the interior windows are made of wired glass. This is a wise measure, since this glass does not splinter freely. The type used is almost too thin,

All sash is of metal. Outside windows have triple sash, an arrangement which is in use throughout the hospital and has no particular significance in regard to the care of mental patients. The lowest of the three is glazed with obscured glass, but since the patient can push it up, the view across the court is unobstructed.

Radiators are placed in recesses under the windows and are protected by perforated metal covers.

Floors in service rooms and sitting rooms are of cheerful red quarry tile. The base is of terrazzo. In the corridors there is a ten-inch margin of terrazzo, with linoleum on the treadway.

Since there are pipe chambers, no undue amount of plumbing is in sight. Toilets seats are balanced by a heavy metal ball so that they fly up when not in use; thus far, little trouble has been experienced, although such brass balls might be a temptation to some mischievous or hostile patient. Toilets have the Boston vent in addition to the general vent. Marble has been installed around the toilets. Wash basins have been set rather low. The faucets are without automatic closing valves.

Diet kitchens are carefully planned. Steel cupboards have been installed and partitions built up from them to the ceiling, so that dust cannot collect on them. Dishes are sterilized before washing. The utility room has proper equipment.



View of hydrotherapy room showing arrangement of equipment.

No linen room has been supplied so that a suitable cabinet has been built in the side corridor.

The rated capacity of the ward is thirty-eight, but as many as twenty extra patients have been carried over night.

The plan of this ward was carefully worked out and the result has been satisfactory in most respects. Central control is obtained to a large degree and patients can be well classified on the

basis of behavior. One would prefer tubs for the prolonged bath on the same floor with the patients, and might raise a question as to whether the best type of outside window was installed, but these are matters of opinion. No one who is planning an observation ward can afford to pass this one unheeded. It is well-arranged, well-equipped, of fire-resistant materials and an integral part of a general hospital.

## THE DIAGNOSTIC CLINIC—A NEW ESSENTIAL OF TWENTIETH CENTURY MEDICINE

BY MICHAEL M. DAVIS, JR., EXECUTIVE SECRETARY COMMITTEE ON DISPENSARY DEVELOPMENT OF THE UNITED HOSPITAL FUND, NEW YORK, N. Y.

A DIAGNOSTIC clinic may be defined as a clinic which limits its work to the study and diagnosis of an ambulatory patient's condition without any responsibility for treatment. In so far as a diagnostic clinic serves patients referred by physicians to whom a report is to be made, the term "consultation clinic" rather than "diagnostic clinic" might be applied. "Diagnostic clinic" should be regarded as the more general term, since it characterizes the nature of the work and the responsibilities of the clinic. "Consultation clinic" is a more special and limited term, which covers part of the possible field work of a diagnostic clinic.

Because of the general interest in this subject, there are described in this article two successful diagnostic clinics at representative institutions. A discussion of the merits and demerits, the principles and the policies of diagnostic clinics must be reserved for another time. Three aspects of the diagnostic clinic, however, may be briefly mentioned.

### Three Aspects of the Diagnostic Clinic

From the point of view of the public, the diagnostic clinic may be regarded as a response to the increasing efficiency, complexity, and cost of adequate diagnostic service which often places it beyond the reach of persons of moderate means, as well as of the poor.

From the point of view of the private practitioner of medicine, a diagnostic clinic may be regarded as a response to the professional need for consultation service which the advance of medical specialties and of technique has rendered more important and more difficult for the average practitioner to secure for the benefit of his patients and of his own growth in professional knowledge.

As a part of an out-patient clinic or dispens-

ary, the diagnostic clinic may be regarded as a coordinator of the various general and special services which are required for the cases presenting obscure or difficult problems for diagnosis.

### Buffalo Central Diagnostic Clinic

The city of Buffalo has established small branch dispensaries at various places throughout the city where applicants are examined thoroughly by the physicians in charge. These physicians are externs operating out of the Buffalo City Hospital. This duty in dispensaries is part of their training as interns at the Buffalo City Hospital. In direct supervision of this work there are three full-time graduate physicians who have completed at least one year of hospital work. The director of the Central Clinic for Adults is in charge of all these dispensaries. He also is assistant medical superintendent of the Buffalo City Hospital, in charge of the admission and discharge department. In addition to six branch dispensaries there are two central dispensaries, one for children, and one for adults.

In the branch dispensaries minor cases are immediately diagnosed and treated, but if the patient's condition seems more than trivial, he is referred directly to one of the two central dispensaries, the one for adults (over fourteen years of age) being at the Buffalo City Hospital, the other at the Children's Hospital, an affiliated institution. Here all more than trivial ambulatory cases are put through an elaborate series of tests which are so arranged that the final review takes place on the fourth day.

*Procedure*—A new patient coming in on a Monday is given a general medical examination and a detailed record is made of his history. The usual routine laboratory tests are made. Each patient is then interviewed by the chief who has the results of the general medical examination and the



medical history at hand. Any special diagnostic tests which may be required take place on Tuesday and Wednesday. On the basis of all these examinations, cases are referred by the clinic director to specialists on the attending staff of the Buffalo City Hospital who, upon request, examine patients and give their opinion on Thursday. When these consultations are over the patient again has a personal interview with the clinic director who explains to the patient the results of the various examinations and tests, and outlines the treatment, following out the recommendations made by the consultants. The latter do not give diagnoses nor instructions directly to the patients.

It is noted that under this system the new patient spends the greater part of four days at the dispensary. At the end of this time, in most instances, a diagnosis is made and agreed upon by several doctors. Ordinarily further tests are unnecessary. Certain cases of unusual difficulty may require a longer time. All steps for determining the diagnosis are taken in four days instead of being spread over several weeks, as is apt to be the case in the ordinary dispensary. Moreover, every new case receives a diagnosis which is reviewed by the clinic director.

**Records**—There is a central record room for all Buffalo City Hospital in- and out-patients, and all patients treated in private hospitals at public expense. The "unit number" plan prevails.

Case records for the whole city are kept at a central record room after they are closed at any branch dispensaries. Every patient registered in any Buffalo City Hospital dispensary is immediately reported to the central record room and any former history consulted. Closed cases are reviewed by the clinic director before being sent to the record room. A case is closed (a) if it is a diagnostic case referred to a private physician for treatment, or (b) if the patient has not returned for treatment within three months, or (c) if treatment is completed.

The central record room makes out an index

card for each individual reported from the branch dispensaries. Each card contains the name, age, address, central index or file number, local dispensary number, and a brief statement of physical defects or diagnosis. These are kept in the large index file. Lists of new patients are sent in daily by the branches. These are checked and the proper central dispensary number is attached to each name. Copies are returned to the branch dispensaries. Indication is also made as to whether a patient is an old or new case in the central record room. Since all physicians in the dispensary are on regular service at the central hospital it is easy for them to look up past histories of patients who interest them. Theoretically, city medical records are available for any patient, no matter where or when he receives treatment.

*Clinic routine*—Monday and Thursday are reserved for new cases. Treatment clinics for old cases are held Tuesday, Wednesday, Friday and Saturday. Outside doctors come in for these treatment clinics, either to observe or to bring patients.

When a patient is admitted he goes through the following routine: after registration, his medical history is taken by an intern or student under direction. He then goes to a central

dressing room where he strips, puts on an examining robe and dressing gown, and starts on his clinic round. Clothes are checked in the check room, first being placed in sanitary bags.

When he enters the main dressing room a slip is pinned on his bath robe. The color of the slip indicates the clinic to which he is to go. No names or numbers are called but patients are sorted by slips. Nurses in the halls note the slips and direct the patient. History charts are carried by the patient in an envelope.

### What Examinations Include

The routine examinations through which every new patient goes on Monday include medical history, physical examination, eye, ear, nose, throat, dental, either gynecology or proctology, urine, Wassermann, blood pressure, blood count.

## A Two-Fold Need

**D**IAGNOSTIC clinics have come into being in response to the demands of people of moderate means for decreased cost of adequate diagnostic service as well as clinical treatment.

These clinics are also a response to the professional need for consultation service which the advance of medical specialties and technique has rendered more difficult for the average practitioner to secure for the benefit of his patients and his own growth in professional knowledge.

Such clinics are needed to coordinate the various general and special services required or cases presenting difficult problems for diagnosis.

On Tuesday and Wednesday are given x-ray and such additional laboratory examinations as are necessary not only to make diagnoses but to discover possible defects. All laboratory results must be in the clinic director's office by Wednesday night. X-ray plates with the radiographer's interpretation are ready in the clinics when the specialists arrive for consultations, on Thursday.

On Thursday afternoon all findings and recommendations are dictated by the clinic director to the dictaphone in the presence of the patient, the clerk and the district nurse. The nurse makes note of social service which is recommended.

**Student training**—Ten senior medical students at a time are assigned to work in the central dispensary. On Monday afternoon each student receives a patient. He takes his history and accompanies him through all the clinic tests. At each step his work is supervised by a graduate physician. The reports he writes are on sheets of different color so that there may be no chance for confusion.

At the conclusion of the routine examination on Monday afternoon each student accompanies his patient to the clinic director's office and asks for such extra diagnostic examinations as he thinks are called for. The chief then catechizes the student as to the reasons for the requests and grants, refuses, or adds others. Wherever possible, the student assists in making the extra diagnostic tests and is also present at later consultations.

**Diagnostic index**—A small index file is kept at the diagnostic clinic containing for each case the name, address, age, date, main diagnosis, and all interesting findings, as well as the dispensary and central file numbers, the agency referring the patient, and whether or not the case is handled by the visiting nurses' association. A summary of the treatment is added. Two examples are shown.

It will be noted that on the first a summary of the defects found according to Bellevue nomenclature is given in the left margin, showing that this patient has five major defects, the second having eight. The principle disease or condition is underlined at the top of the card.

**Four years' work**—Between March 1920, and January 1924, there were 5,304 patients examined in the diagnostic division, at the rate of about 115 a month. These patients were found to have an average of nearly five defects apiece, a defect meaning any distinct pathological entity, and including both diseases and functional or structural abnormalities. A total of 23,549 defects as recorded.

Private physicians referred 1,314 of the cases,

or a quarter of all. Of these, 1,149 were sent by local, and 165 by out of town practitioners.

BERGER, MARY		3-23-22
Diabetic Mellitis		F. Age 49
Eye	1. Error in refraction.	4. Lacerated perineum.
Ear	2. Shortened bone conduction of ear.	5. Diabetes.
Gyn	3. Relaxed perineum.	6. Syphilis.
Med	Disability 50 per cent indef. District Nurses Association. Erie County Board Child Welfare.	
Urol	4-4-22	
	3369	65080
Blood sugar, Friday, 9:00 A. M. Refraction, diabetic Cl., Wed. P. M. Wassermann to be repeated at this time to question as to value of giving patient salversan.		

Eye	AGRAPETA, THERESA	
	<u>Fibroid Uterus</u>	
Ear	1. Error in refraction	7. Marked secondary anemia
N & T	2. Chronic mastoiditis	8. No pul. tb.
Dent	3. Small cryptic tonsils	9. Retroversion and enlargement uterus
///	4. Dental caries	10. Fibroid tumor in uterus
Gyn	5. Oral sepsis	
	6. Alveolar abscesses	
	Disability 50 per cent one month.	
	D. N. A. Branch Dispensary No. 5 B. P. W.	
	6-11-23	86130
	4927	
Report for Eye, Gyn., and Medical Clinics on Wed. at 1:00 P. M. Dental care at H. C. No. 5 on Saturday at 2:00 P. M. Patient needs gyn. operation.		

Index file cards used in Buffalo City Hospital diagnostic clinics.  
The second patient has eight defects requiring treatment in five clinics.

### Cornell Clinic Consultation Service

At the Cornell Pay Clinic the diagnostic service is in the department of medicine.<sup>1</sup> While this service is available for the other departments of the clinic, a special procedure is followed in the case of patients sent in by private physicians for consultation only, or for consultation and treatment.

Every general practitioner has patients who can meet his fees for the daily run of ills that flesh is heir to, such as acute upper respiratory tract infections, other acute self-limited diseases or minor surgery. But when the same patients are faced with obscure conditions needing the internist or one or more other specialists, as well as diagnostic procedures like x-ray, blood chemistry, basal metabolism or electro-cardiography, the case is quite different. For these the consultation clinic at Cornell meets a real need and the records show that private practitioners are taking increasing advantage of its service. Thus among 4,425 patients referred to the consultation service during the first two years, 2,708 were referred during the second year, as compared with 1,717 in the first, or an increase of nearly 1,000 patients.

The patient sent in only for consultation pays \$10 for as many visits to as many specialists as may be necessary to reach a diagnosis, plus rou-

1. Abstract from the annual report for 1923 by Dr. George H. Bigelow, director.



tine blood and urine examinations, with additional x-ray and laboratory work charged at regular clinic rates. He is first given a general examination and such exploration tests as may be indicated are called for. After these are reported the patient returns to the doctor who first saw him, who sums up all the available data and reports in writing to the referring physician. Patients coming with specific requests, as for an eye examination, are sent directly to the department mentioned. When treatment is also requested the patient pays the regular clinic rates, but in all cases a written report is sent after a diagnosis is reached.

### Service Value Depends Upon Promptness

It is recognized that the value of this service is roughly in proportion to the promptness with which it is rendered. Because of the volume of work and the multiple consultations and tests required, it has been found that the average time interval between the first visit to the consultation clinic and the dictating of the report is two weeks. Cases going directly to a specialist can obviously be reported more promptly. This delay has caused occasional irritation to the referring physician. But in general it is felt that the physicians showing the greatest impatience in the delay incident to such examinations as fluoroscopy, basal metabolism, and electro-cardiography are those who appreciate least the significance of such work.

The clinic committee of the university faculty felt that in these cases the customary question of economic eligibility need not be raised since the physician in sending the case to us had passed on this matter. However, there was some question as to whether certain physicians might not be influenced in his selection of cases primarily by economic rather than medical reasons. This was effectively answered last spring when the diagnoses of the first 1,500 cases were collected by departments and submitted to the respective clinic chiefs and department heads in the faculty. It was decided that from seventy-five to eighty-five per cent of the diagnoses clearly indicated real problems warranting consultation service. Of course, this study was superficial but any considerable abuse of the service would have been apparent from such a survey of diagnoses.

**Medical ethics**—There seems little doubt that such a department is of real service to the private physician and the patient. It is in connection with the consultation service that the most frequent ethical difficulties arise. Inevitably where such a large volume of work is handled, there are patients who for one reason or another have

gained confidence in the clinic staff and desire to remain for treatment. It is explained that the clinic sets for itself the same standard of ethics that would apply, were it an individual private physician. This they generally do not comprehend, and ask often if they are chattel to be owned by one physician or another. They are told that, of course, the clinic cannot pretend to dictate as to whom they shall go and that they may go for treatment to any one they desire except the clinic, unless they bring a letter from a physician specifically requesting treatment.

In this connection it is worth noting the number of regular patients that are under the care of a private physician at the same time that they come to the Cornell Pay Clinic. This is routinely asked at admission and, when they admit being under medical care at the time, they are referred to their physician for a note requesting treatment. But again and again after treatment has been started it is learned that they are under private medical care. This is, of course, inevitable in a certain number of acute conditions, since Cornell has no hospital and is not open Saturdays and Sundays, or nights, and but rarely provides for visits to the homes. When such facts are picked up it is the policy to return the patient to his physician and report the findings, if desired. One patient who had not been back to the clinic for a year disclosed in conversation that he was under active treatment with two private physicians and a chiropractor. It would be interesting to know in how large a percentage of the practice of the average general physician other doctors are being consulted without his or their knowledge.

### ILLINOIS PHYSICIANS ASKED TO HELP COMPILE MEDICAL HISTORY

Under the sponsorship of the Illinois State Medical Society there is in preparation "A History of Medical Practice in the State of Illinois" which will go to the printer at an early date. In order that this volume may be accurate and complete, all possible assistance is asked from every source, as to personal data and experiences, including diaries, photographs and similar documentary memoirs of pioneer Illinois doctors and of progressive phases of medical practice, as well as of achievements in fields other than those of medical science. Prompt return in good condition is promised for anything loaned the committee, the personnel of which is: O. B. Will, M.D., Peoria; C. B. Johnson, M.D., Champaign; Carl E. Black, M.D., Jacksonville; George A. Dicus, M.D., Streator; James H. Hutton, M.D., Chicago; Chas. J. Whalen, M.D., Chicago, chairman.

The scope of the volume will range from the pioneer days of Illinois to modern times. Through this period of over 250 years there is much of interest to be detailed. Collection of human interest data can come only from families or closest friends of the pioneers, many of whom long ago removed to distant parts of the United States.

## THE BUILDING PROGRAM OF THE SHRINERS' HOSPITALS FOR CRIPPLED CHILDREN\*

BY HAL F. HENTZ, HENTZ, REID & ADLER, ARCHITECTS, ATLANTA, GEORGIA.

**T**HE Portland unit site is a beautiful ten-acre tract on the Sandy Boulevard just outside of the city limits. As Sandy Boulevard is the main feeder for the famous Columbia River Highway, this means that practically every visitor to Portland will pass the hospital site. The hospital faces due north with the ground sloping from the building down to the boulevard, and then on down to the Columbia River. Across the river is Washington with Mt. Adams and Mt. St. Helena in the distance, while almost directly east is Mt. Hood; all snow-capped peaks.

As the grade slopes sharply the building is one story higher in front than in the rear. The out-patient department is on the ground floor, west wing, this being the closest to the main entrance to the grounds. This department has the customary waiting room, office, examination rooms, plaster room and gymnasium.

The main entrance is in the center of the building with a double stair leading from a panelled hall to the floor above. This main stair hall is finished in oak in typical English style. The admittance and x-ray rooms are to the right of the main entrance, being closest to the out-patient department, while the quarters for female help are to the left of the entrance. The boiler room is at the rear of the center wing with outside entrance from a court area. The boiler room contains the heating and refrigerating plants with an emergency coal storage room in the rear. The

laundry contains the usual washer, extractor, ironer, presses and ironing boards.

The east wing contains bedrooms for the male help, a workshop and a garage with space for four cars.

The hospital proper is all on the main floor with wards opening directly out on the play grounds to the rear. These play grounds, separated by the service drive, will be equipped with various apparatus for the children, together with a small play house for the girls.

As the building faces north, it was necessary to place the service portion of the wings on the north, so as to give the most sunlight to the wards and solariums. In the center wing the office and reception room are on either side of the entrance hall, with the various other offices and quarters for the superintendent and interns occupying the balance of the front.

The kitchen occupies the center rear wing and is complete with store and refrigerator rooms. The operating suite is over the laundry and has the usual rooms opening off a separate corridor.

The top floor is exclusively for the nurses, the rear bedrooms being for the apprentices and the front rooms for the graduate nurses. A large living room with light on three sides, containing fire-place and library alcove is provided at the west end of this floor.

### Home Atmosphere Preserved

It was felt that a building of this type should have the appearance of a large home rather than

\*This is the second and last article on the building program of the Shriners' Hospitals for Crippled Children. The first appeared in the July issue, page 27.



Drawing of the Shriners' Hospital for Crippled Children, Portland, Oregon.





a hospital and the modern English style was selected as being best adapted to the idea. The walls are of concrete faced with selected common brick with enough variation in color to give a delightful texture. The roof is covered with copper shingles stained green. A portion of the brick is painted cream color to match the trim and the same color is carried as a band entirely around the building just below the upper bedroom windows.

The Architects for the Portland, Ore., unit are Messrs. Sutton and Whitney of Portland.

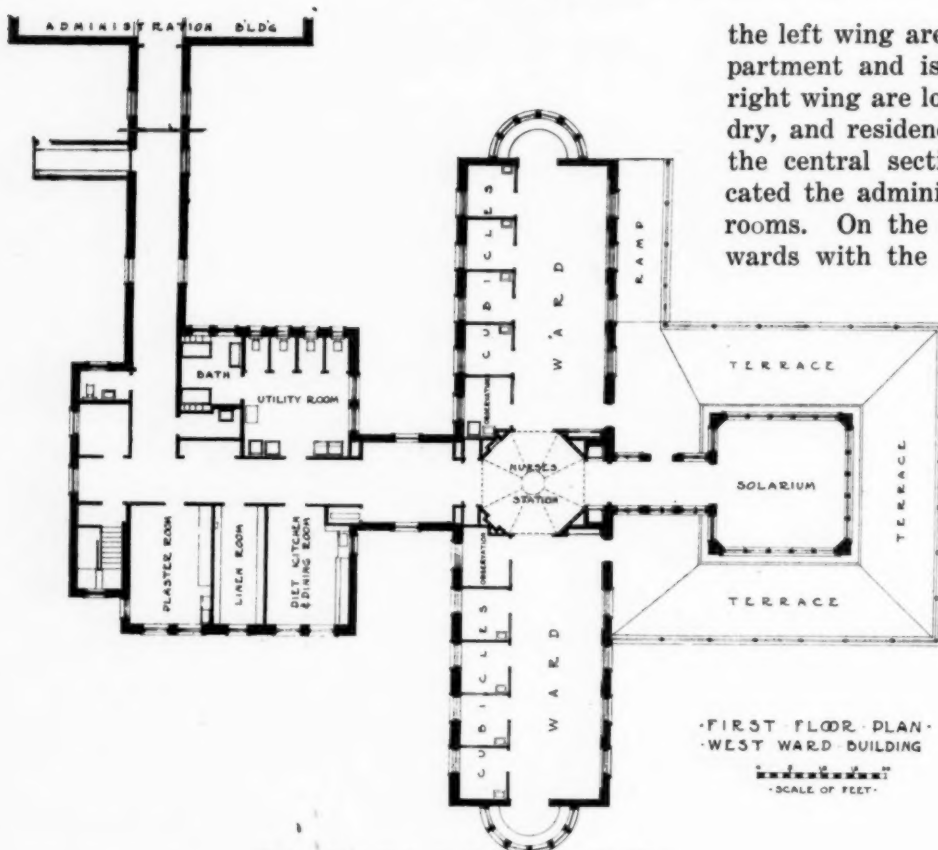
### The Twin Cities' Hospital

The Twin Cities, unit is located about halfway between Minneapolis and St. Paul overlooking the Mississippi river. The group consists of a central administration building, two ward build-

ings, a garage and service building. The property faces southeast. The administration building consists of a basement and three floors. In the basement are the laundry, the shops and store rooms; on the first floor, administrative offices, general kitchen, nurses' dining room, etc; on the second floor, operating suite, x-ray laboratory and intern's quarters; on the third floor are the nurses' quarters.

The ward unit differs somewhat from the Shreveport and San Francisco ward plan in that it does not provide separate service for each group of children. A large solarium surrounded by terraces, is located between the two wards, one diet kitchen, one large surgical dressing room, a large utility and bath room serve the two ward divisions. The out-patient department is located underneath one of the ward buildings where it





Twin Cities' Unit, St. Paul-Minneapolis, Minn.

is easily reached from the street. The architects for this unit are Messrs. Buechner and Orth and Bertrand and Chamberlin.

#### St. Louis Unit in One Building

The St. Louis unit is located adjacent to the Barnes Hospital and overlooks the city park. This institution differs somewhat from the typical layout in that it is all contained in one building. Provision is made for eighty beds. There are two wards on the first and second floors. In the central section of the building, between the two wings are located the administrative offices, receiving department, operating suite, and interns' quarters; the basement is used for kitchen, storage, laundry, etc. The heat and power for operating the hospital is secured from the Barnes Hospital central plant. The nurses are housed in a separate building in connection with the hospital. The architect for this institution is Mr. William B. Ittner of St. Louis.

The Montreal unit is located close to Mt. Royal Park on a sloping piece of ground. Because of the limitations of the property, the essential elements of a typical hospital have been most successfully grouped in one building by the architects, Messrs. J. Melville Miller and Hugh Valance. Only the basement under the front portion of the building is utilized on account of the sloping ground. In

the left wing are located the out-patient department and isolation department; in the right wing are located the boiler plant, laundry, and residence quarters for interns. In the central section of the building are located the administrative offices and waiting rooms. On the first floor are located four wards with the various service rooms, the general kitchen and the nurses' dining room. The nurses' and help's quarters are located on the second floor. The operating suite is located on the third floor.

The Springfield hospital, Springfield, Mass., site is an absolutely level, seven-acre tract, located at the intersection of Carew Street and Melha Avenue, highly elevated, overlooking the entire city. It is only about ten minutes' ride from the center of the city by street car. The

hospital is planned on the pavilion type; the entire group of buildings faces due south. The group consists of one main administration building, two ward buildings, a nurses' home and out-patient building, an isolation pavilion and a garage building. In the administration building is located the administrative offices, visitors' waiting room, main kitchen and nurses' dining room, all on the first floor. In the basement are placed the heating plant, laundry, engineer's quarters, and store rooms. On the second floor are located the operating suite, and interns' quarters.

Each ward building is practically the same as that at Shreveport, San Francisco, and Atlanta, with the exception that certain parts have been enlarged and made more convenient. For example, the porch is enclosed in glass so that it can be used for bed purposes both summer and winter. In the summer the sash will slide out of sight, thus making an open porch. The day or play room has been made larger and of a shape that will accommodate a big round table where the children can be instructed in kindergarten work.

The out-patient department has been arranged on the first floor of the nurses' home and its entrance is direct from Melha Avenue, the side street, only a few steps from the street car line. Female helps' quarters are provided in one of the wings on the first floor of this build-



ing. The entire second floor is used as a home for the nurses, the graduate nurses occupying one wing and the pupil nurses the other, each having separate recreation rooms.

The isolation pavilion indicated on the plan is not provided for in any of the other institutions with the exception of the Montreal unit. The advisory doctors and the supervising nurse feel that provisions should be made for an isolation department in each of the institutions to be constructed in the future.

The garage building, in which are located repair shops, brace shop and male help's quarters is in the rear of the administration building.

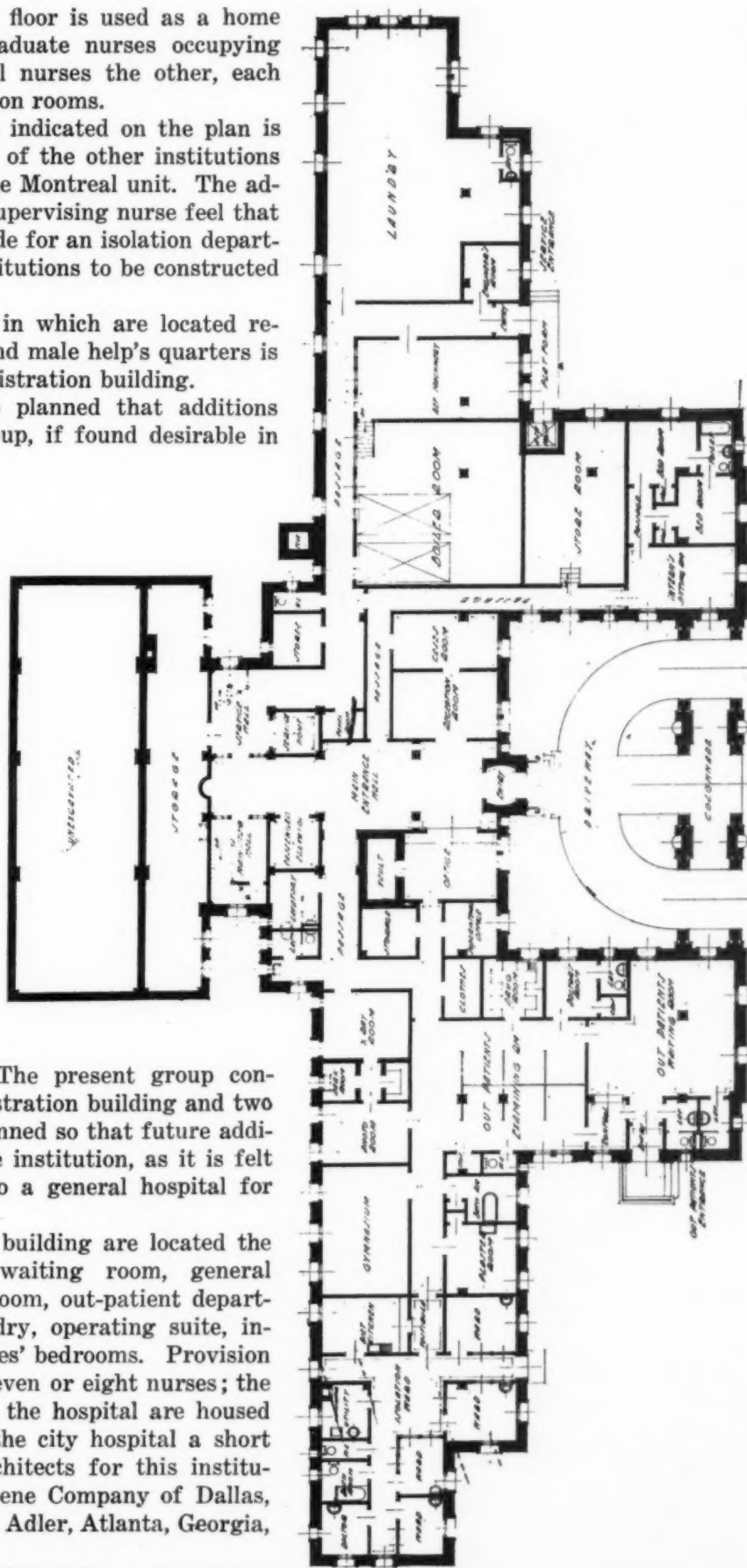
The buildings are so planned that additions can be made to the group, if found desirable in the future.

The group is designed in early colonial style of dark red brick with trim of limestone. The architects for this institution are Messrs. Hentz, Reid & Adler, of Atlanta, Georgia, and Mr. M. H. Westhoff, Springfield, Mass., associate architect.

In Dallas, Texas, as stated before, Hella Temple has constructed and is maintaining its own institution for the treatment of crippled children. The property is an entire city block. The present group consists of a central administration building and two ward buildings. It is planned so that future additions can be made to the institution, as it is felt that it may develop into a general hospital for children.

In the administration building are located the administrative offices, waiting room, general kitchen, nurses' dining room, out-patient department, boiler room, laundry, operating suite, intern's quarters, and nurses' bedrooms. Provision is made for only about seven or eight nurses; the other nurses working in the hospital are housed in the nurses' home of the city hospital a short distance away. The architects for this institution are Herbert M. Greene Company of Dallas, Texas, and Hentz, Reid & Adler, Atlanta, Georgia, as consulting architects.

Plans for the Philadelphia unit are now being



J. WILFILL, MILLER, & CO.  
ARCHITECTS  
MONTREAL, CANADA

SHEDDEN'S HOSPITALS FOR CRIPPLED CHILDREN  
MONTREAL, CANADA

SCALE 1/4" = 1'-0"

completed by the architect, Mr. Philip H. Johnson, Philadelphia. It is to be located on a beautiful tract of land overlooking Roosevelt Boulevard, some five or six miles from the center of the city.

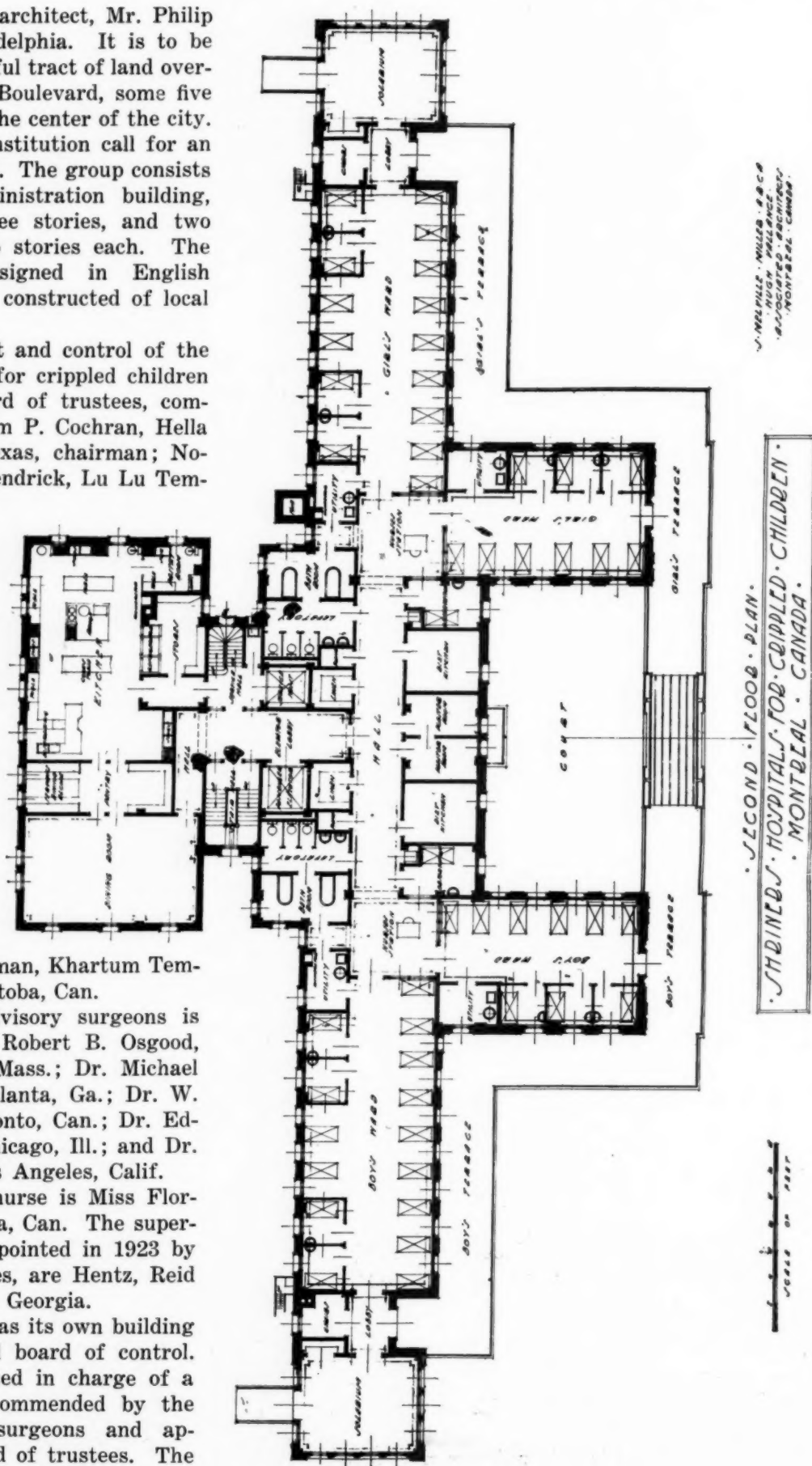
Plans for this institution call for an eighty-bed hospital. The group consists of a central administration building, basement and three stories, and two ward units of two stories each. The buildings are designed in English Gothic style to be constructed of local stone.

The management and control of the Shriners' hospital for crippled children rest with the board of trustees, composed of Noble Sam P. Cochran, Hella Temple, Dallas, Texas, chairman; Noble W. Freeland Kendrick, Lu Lu Temple, Philadelphia, Pa., vice-chairman; Noble Forrest Adair, Yaarab Temple, Atlanta, Georgia, secretary; James R. Watt, Cyprus Temple, Albany, N. Y.; Noble John D. McGilvray, Islam Temple, San Francisco, Calif.; Noble Dr. Oscar M. Lanstrum, Algeria Temple, Helena, Montana; Noble Arthur Chapman, Khartum Temple, Winnipeg, Manitoba, Can.

The board of advisory surgeons is composed of Dr. Robert B. Osgood, chairman, Boston, Mass.; Dr. Michael Hoke, secretary, Atlanta, Ga.; Dr. W. Edward Gallie, Toronto, Can.; Dr. Edwin W. Ryerson, Chicago, Ill.; and Dr. John C. Wilson, Los Angeles, Calif.

The supervising nurse is Miss Florence Potts of Ottawa, Can. The supervising architects appointed in 1923 by the board of trustees, are Hentz, Reid & Adler of Atlanta, Georgia.

Each institution has its own building committee and local board of control. The hospital is placed in charge of a surgeon who is recommended by the board of advisory surgeons and appointed by the board of trustees. The

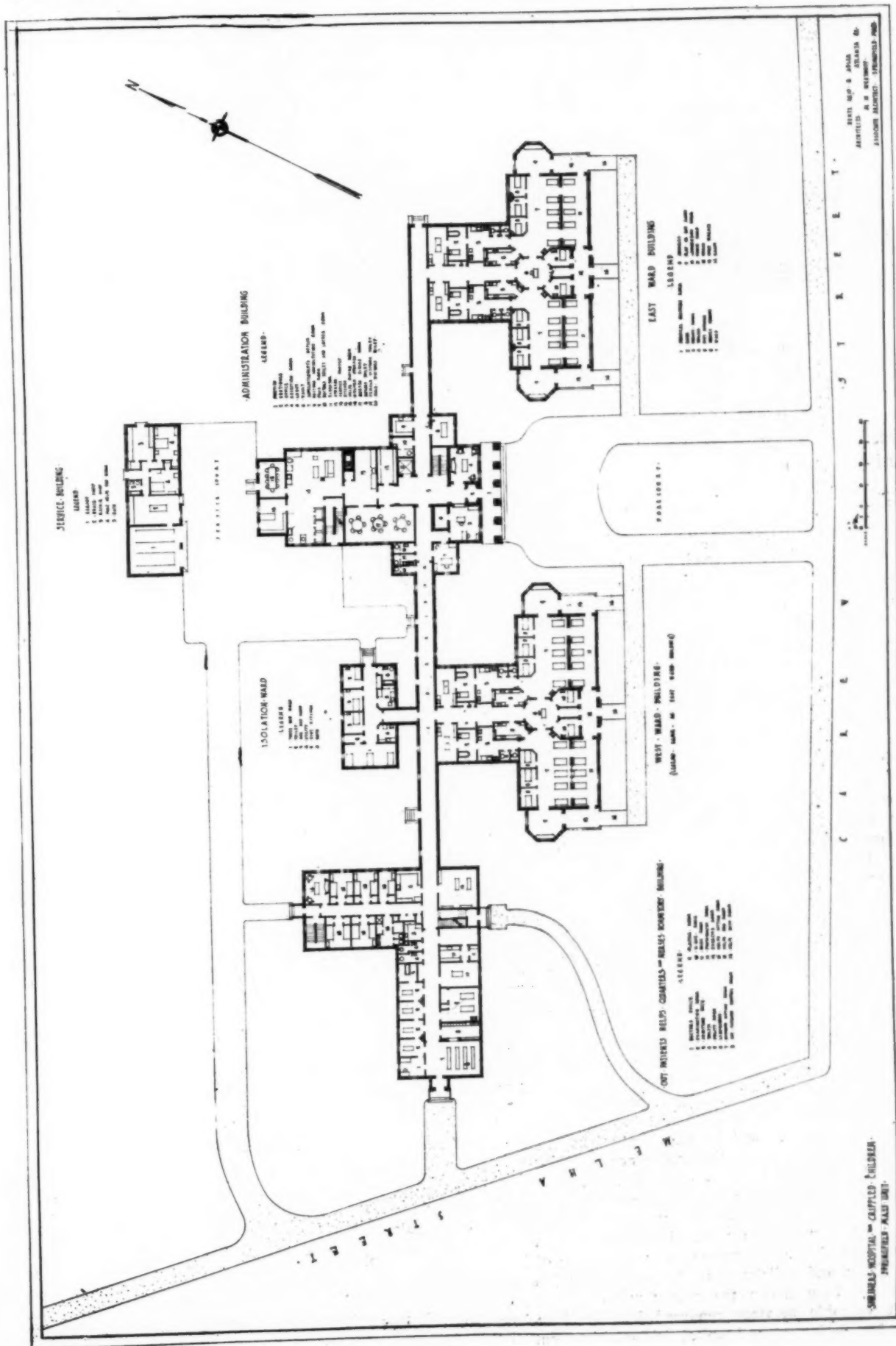


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SHRINERS' HOSPITALS FOR CRIPPLED CHILDREN  
MONTREAL, CANADA

1" = 10' - 0"







Drawing of the Hella Temple, Dallas, Texas.

local surgeon sees to the employment of the entire operating staff of the institution. Periodical reports are made to the board of trustees covering the operation of each institution, and in so far as possible the operation of these institutions is becoming standardized. In like manner the planning of a typical institution will, in due time, be practically standardized. Out of experience developed in this work, not only will new methods of treating the crippled child be found but in time a plan ideally suited for this work will evolve.

#### INTEREST CENTERS ON A. H. A. BUFFALO CONFERENCE PLANS

The twenty-sixth annual conference of the American Hospital Association to be held in the 106th Regiment Armory, Buffalo, N. Y., October 6 to 11 bids fair to outrank any previous meeting both in the values of the program and the exposition and in the attendance of members and delegates.

The conference will open at 9 a. m. Monday, October 6, and continue until 4 p. m., Friday, October 10. Officers and committees are now at work on the detailed plans to make the conference unsurpassed in practical value to the hospital people in attendance. The local committee on arrangements, under the chairmanship of Dr. Walter S. Goodale, superintendent, Buffalo City Hospital, is making elaborate arrangements for the comfort and enjoyment of what promises to be the largest gathering the association has ever had. Details of the program will be announced in the September issue of *THE MODERN HOSPITAL*.

Buffalo is ideally located for such a meeting, as more than half the population of the United States and Canada live within a night's ride of that city. The armory provides one of the finest exposition floors in the world and affords ample meeting halls for both general and sectional meetings. It will be easy and inexpensive to combine with attendance at the conference, visits to hospitals in the East and the Middle West. Special arrangements are being made for visiting the hospitals of Buffalo, New York City and Brooklyn.

The program, now nearly completed, promises to be the most interesting and comprehensive discussion of hospital problems and policies that the association has yet had. As has been shown the past few years, some of the most valuable services rendered by the American Hospital Association to the hospital field are the results of

the work of its several special committees. The presentation and discussion of the reports of these committees will form an important part of the program of the twenty-sixth conference.

#### Prominence Given to Small Hospitals

There are perhaps two distinctive features of the Buffalo conference which deserve special comment. One of these is the special emphasis which will be placed on the work of small hospitals. There are many more small hospitals than large ones and in many instances their problems are more acute and difficult of solution than are those of the larger, better financed, metropolitan institutions. This year the small hospital section has been strengthened and special attention to the problems of small hospitals is given in the programs of several of the other sections. For example, the social service section will feature the subject of social service in small hospitals.

#### Attention to Center on Patient Grouping

Another significant aspect of the program, indicative of the broadening scope of the interest of the association, is the attention it will bring to a consideration of the needs of special groups of patients, particularly, psychiatric, tuberculous and incurable patients. The committee on out-patient work will bring in a further and perhaps final report on ideals and policies for the administration of clinics.

The association will have its own publicity and National Hospital Day booth and will be equipped to advise hospitals in relation to their publicity problems.

As in former years, the American Association of Hospital Social Workers, the American Occupational Therapy Association, the Protestant Hospital Association, and the Hospital Dietetic Council will meet with the association.

There will be larger numbers of commercial exhibitors, a more comprehensive exhibit and much greater exposition space than at any previous conference.

#### Hotel Accommodations

For the convenience of readers who wish to make hotel reservations in advance, we are listing below the names and available accommodations of thirteen leading hotels of Buffalo.

Hotel Broezel	Hotel Buffalo
—50 rooms	—200 rooms
\$2.50 up single	\$3.00 up single
\$4.00 up double	\$5.00 up double

(Continued on page 194)



## ARE HOSPITALS GETTING WHAT THEY PAY FOR?\*

By JOHN C. DINSMORE, Ph.B., PURCHASING AGENT, UNIVERSITY OF CHICAGO, CHICAGO, ILL.

THIS brief article may properly be regarded as a series of instances where the buyer either did not get what he paid for or failed to secure as much for his money as he might reasonably expect. In some instances, after his attention had been called to the discrepancy between what he thought he was getting and what he did get, he was able to get an adjustment. In many cases, however, no adjustment was made and the hospital buyer paid dearly for his experience. In this report of actual occurrences no attempt has been made to point out a moral but in some instances the author has ventured to indicate a procedure which might have saved the buyer and his institution much trouble and expense.

Some five years ago the superintendent of a great institution in the Middle West was in the market for furniture for a 250 bed hospital. He wanted to purchase substantial furniture having good lines, and was particularly anxious to secure a durable dark finish. His attention was called to a good looking line of furniture with a new lacquer finish which the salesman said was water- and alcohol-proof. He was much interested in the various "stunt" tests to which various samples of finish were put and finally placed the order for the furniture with the wonderful new finish. He did not, however, ask either the manufacturer or the jobber to give him a written guarantee of the durability of the finish.

While the finish was new, it was water- and alcohol-proof but after six months' service the finish lost its life and turned white when subjected to water, and a drop of alcohol dissolved the lacquer finish as easily as shellac. When the

superintendent complained to the jobber and later to the manufacturer he was informed that the employees of neither were authorized to guarantee the finish on this furniture and that the men concerned were no longer with them. The manufacturer did offer to refinish the furniture at cost but even then the cost of removing traces of the old finish and applying the new finish was almost prohibitive. Thereafter this hospital superintendent decided to restrict the hospital experiments to the laboratory and to specify

standard finishes and standard goods only. Moreover, he now sees that all guarantees concerning any commodity he buys are put in writing by a responsible member of the firm with whom he does business.

The buyer for a hospital in a southern state used a quantity of waxed paper. One particularly warm summer the wax on the paper melted and the paper stuck together. After several attempts to separate the paper he finally sold it for waste. The waste paper dealer who bought it put in an ice box until it was thoroughly chilled and the sheets separated easily.

Many hospital superintendents buy large quantities of canned and other goods in order to get a lower unit price. Sometimes these theoretical savings are realized, but all too often the interest on the investment, the shrinkage and depreciation more than offset the saving. More and more you will find that the most efficiently operated hotels buy in small quantities and turn their stock often. The maximum stock carried in the commissary department of one of Chicago's greatest hotels is less than enough to last two days. The actual stock turnover is over two hundred times per year.

### Some Buying Ethics

MANY hospital superintendents buy large quantities of canned and other goods in order to get a lower price. Sometimes these theoretical savings are realized but all too often the interest on the investment, the shrinkage and depreciation more than offset the saving." . . .

"There are certain types of goods used by every hospital which are habitually sold at prices bearing but little relationship to the cost of production. . .

"Dealers and manufacturers can continue to get fancy prices on certain items only as long as the purchasing agents are uninformed." . . .

"Many lines of goods may nearly always be purchased to better advantage during certain seasons of the year, and it is not very difficult to learn just when these advantageous buying periods come."

\*This is the fourth of a series of articles on hospital purchasing prepared for THE MODERN HOSPITAL by Mr. Dinsmore.

### Economy in Replacing Light Globes

The lamps one buys are guaranteed to deliver an average of 1,000 hours of service, and those lamps which do not give satisfactory service will ordinarily be replaced free of charge. By inspecting the burned out lamps one can readily pick out those which have not delivered a reasonable amount of service. This can readily be determined by examining the filament through a reading glass. This filament slowly crystalizes under service and the non-crystalized filament is found only in the lamp which has given very little service. Another test is to examine the little round labels on the lamp stem. Under service this label is scorched brown. The lamp with a fresh white label has rendered little service. It will pay to reinspect your burned out lamps before you part with them. An eastern hospital secured a credit of \$400 on a lot of discarded lamps which were reinspected to find those which had not delivered a reasonable amount of service. It is, of course, only fair to note that any institution whose electric current is subject to marked pulsations can hardly expect the lamp company to replace those lamps which are destroyed by these pulsations.

The business of refilling burned out lamps has been upon a thoroughly disreputable basis until just recently. There is now, however, at least one such company which apparently gives you refilled lamps which are thoroughly trustworthy at a material saving over new lamps.

A little while ago a group of institutions made a comparison of the price paid per gallon for liquid soap. The cheapest cost was eight cents per gallon and the highest price paid was \$2.75 per gallon. Perhaps eight cents is too low a cost for good liquid soap, but if one reputable institution can be satisfied with an eight cent soap it is quite possible that \$2.75 per gallon is too much to pay.

### Prices Related to Cost of Production

There are certain types of goods used by every hospital which are habitually sold at prices bearing but little relationship to the cost of production. Dealers depend upon these goods that carry the "velvet" to make up for the goods which are sold on narrow margins. Dealers and manufacturers can continue to get fancy prices on certain items only as long as the purchasing agents are uninformed. A careful study of the sources of supply and the manufacturing processes of those items which habitually command a high price

will always bring handsome returns. This applies particularly to such items as gases, ether and alcohol, narcotics and surgical supplies. Frequently a careful study of these supplies will develop a substitute material which may not only be cheap but may be more efficient.

### Seasons for Purchasing

Many lines of goods may nearly always be purchased to better advantage during certain seasons of the year. It is not very difficult to learn just when these advantageous buying periods come. Many hospital buyers of experience do, however, ignore this phase of their work entirely, as do a great many purchasing agents for industrial firms. Ordinarily the price of screenings is less when there is brisk demand for prepared sizes of coal and this brisk demand usually comes in July and August. It is then that the average retail coal dealer begins to feel the demand from the most far-sighted householder. This demand is supplied from the retailers' slender stock and he in turn orders more from the mine operator. About this time many other householders and retailers are stimulating this demand for prepared sizes of coal for domestic consumption and the mine operator finds that he is beginning to accumulate an excess amount of fine coal as a by-product. It is then that the hospital superintendent who has ample storage capacity can fill it to advantage. The hospital buyer who has no excess storage capacity but must contract for his needs may also at that time of the year negotiate contracts that are most advantageous. It is interesting to note that even though the coal operator knows from long experience that this over-supply of fine coal is only temporary and that the demand will soon catch up with the supply, he is willing to make generous concessions on contracts running the whole coal year because there is a temporary over-supply at the time the contracts are negotiated.

The hospital buyer who knows the seasonal fluctuations in the coal business is in a position to place advantageous contracts when the right time arrives. There are of course certain variables in the problem. If the price of Pocahontas coal should fall slightly below its present price of \$2.00 at the mine many of the householders who normally buy prepared sizes of Illinois coal will buy Pocahontas instead. If this should occur the demand for prepared sizes of Illinois coal will fall and the expected over-supply of screenings will not be realized and the hospital buyer will not secure his expected bargains.

The same principle applies to practically everything that the hospital uses in large quantities,



Careful students of the cotton market are able to forecast with considerable accuracy the probable trend of the cotton market and so are in a position to place most advantageously their orders for gauzes and bandages. Paper products ordinarily may be purchased to advantage just after Christmas and in August. Belting and hose prices tend to soften in the last three and the first three months of the year. Corn brooms are usually easier in June and July. It is of course true that the price of brooms will tend to increase in these months if it is quite certain that the broom corn crop will be a failure. Ordinarily, clothing prices stiffen a bit in July, August, September and October, and the peak in drugs is usually reached in March, April and October, while food products tend to be higher the last half of the year.

### Analyzing Unit Prices of Goods

Some purchasing agents claim that it pays them to analyze the unit prices paid for the various kinds of commodities they buy in order to determine the time of the year in which they ordinarily get lower unit costs. They then endeavor to place their largest commitments, at that time. However, there is just an element of danger in this. If one's chart is drawn up with so much care and accuracy that it is of any real value in purchasing, it is just possible that the hospital buyer may fall purchasing agent or the into the habit of following that chart blindly. They may work out most of the time but ever so often new elements are injected into the situation and the buyer who follows his chart and does not weigh carefully all the elements in the immediate and the long run price situation may find that he has made an error of judgment and that he actually faces a considerable loss instead of realizing a profit.

Regardless of the skill of the buyer and regardless of the amount of statistical and other data he may have at his command there is some doubt as to the amount of money that may be made by buying very far

in advance. Generally speaking, it is sounder to have accurate data concerning annual requirements of the various items bought and to consummate purchases only far enough in advance to make sure that the staff of the institution will not be handicapped by a short supply.

### FLOATS DEPICT PROGRESS OF CONTAGIOUS DISEASE HOSPITALS

The development of contagious disease hospitals in the past half century was strikingly brought out in the jubilee parade which took place in Winnipeg, Man., June 18, as a part of the celebration of the fiftieth anniversary of the incorporation of the city.

Among the 300 floats two were of special interest to hospital people,—the two depicting the contrast between the pest house of fifty years ago and the modern contagious disease hospital of today. One of the pictures shows the horse-drawn float representing the conditions surrounding the care and treatment of communicable disease fifty years ago by "Ye Olde Pest House" method. The repique comprises a log cabin on a prairie encircled by a "germ-proof" snake fence, in accord with the theory of supposed air infection which prevailed fifty years ago. The germs represented on the float by pine cone figures were suspended on fine wires so that they jumped about in a most dangerous way with the vibration of the wagon. The germ which escaped through the fence was caught by the fireman with his hose just outside the gate.

In contrast to the representation of the pest house of yore is the float of the buildings of the modern contagious disease hospital situated on a twenty-five acre park open to the public where band concerts are held in the summer.





## The MODERN HOSPITAL

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## THE RITUAL

THE psychological element of golf is in no particular better illustrated than in behavior on the tee. A pinch of moist sand is taken carefully, caressed and molded into a cone or pyramid, and a ball superimposed thereon. Right here the psychological element begins to manifest itself. The player who is sure of himself makes the conical tee with a single gesture and in his choice of the ball which is to be placed thereon exhibits no hesitation. The less confident player, however, has to make the tee just exactly a certain way, and some even carry with them small moulds so that all tees may be absolutely uniform. If by misadventure or forgetfulness they do not have the mold with them, their game is entirely ruined. In the choice of the ball to be used there in a similar exhibition of the mental state. If it is a hole with water hazard, some players are rendered absolutely miserable if they do not have a floater to play. Others always choose the oldest ball for certain holes and others try to overcome their phobia by brazenly using a beautiful new ball on the holes where they are most apt to lose them.

Next the player stands off and views his handiwork; he arranges his grip, his stance; he bends his knees, he wiggles; he addresses the ball and finally after standing in rapt contemplation, he comes back, comes down; perhaps he hits the ball and follows through. If he is a self-satisfied man, no matter how exteriorly modest he may appear, his inner conceit is perfectly demonstrated by the movements through which he goes upon the tee. The aggressive, pushing man is apt to undertake to slug the ball with disastrous results, while, on the other hand, he of a retiring disposition is liable to make a short and rather ineffectual drive. The reason for all of these mannerisms is the fact that every human being acquires certain definite habits in the accomplishment of any difficult task. These are hard to break once they become crystallized and always there is the danger that they will grow until they finally engulf and destroy their creator.

In every walk of life we are apt to develop certain rituals. These may be extremely useful in psychologically cranking up the mental machinery to performance but they may eventually turn into obsessions which are a great handicap.

Executives are constantly under the critical observation of those whose efforts they direct, and many of us would be tremendously surprised if we could read the innermost judgments which those who are associated with us have formed as the result of the observation of our habits. The hospital executive who goes to work in the



morning with a chip on his shoulder, noisily challenging the statements of his associates, bullying the timid and being surly and rude to everyone, may in the beginning lose this psychic attitude as the day goes on, becoming a courteous, kindly person by nightfall. But day by day his grouch gradually lengthens until it has completely dominated his character and warped his outlook on life. His boorishness increases until it has become chronically habitual and he has developed into a churlish curmudgeon who cannot get along with anyone. What began as a simple peevishness such as a child may exhibit when first awakened, may end as a violent aberration.

A superintendent of nurses, on entering her office in the morning, may fuss around with everything on her desk. The inkstand must be in a certain place; the books must be arranged according to a certain formula; pencils must be moved to a definite arrangement on the rack; the paper-weight must be exactly in the center of a certain spot and even the window-shade must be raised or lowered until it is in a certain position. These things are harmless enough in themselves but they grow into idiosyncrasies which extend into every corner of the hospital to the annoyance of all concerned and eventually to the great harm of the person who starts out along this route.

No man by taking thought may add a cubit to his stature. He may, however, by careless, fussy or discourteous habits, develop for himself, an attitude of mind which may end in a mono-mania. Certainly it may impair very greatly his usefulness.

It is really a good deal easier to be pleasant without loss of firmness, to be exact without being a crank about it and to be efficient without nagging. Hobbies are bound to be developed by all normal persons, but they should not be obsessions. Above all, a mental flexibility and a keen sense of humor,—that sense which enables us to disassociate ourselves and see how ridiculous a creature man is—will act as a prophylactic against the development of objectionable traits.

Persons who live and work in the enclastered atmosphere of the hospital are more apt to develop mental quirks than those who undergo the constant attrition which comes from intimate association with a hurly-burly world, and therefore they should at frequent intervals take stock of themselves for the purpose of discovering any trivial habits which by their growth may prove harmful. When the weeds of fear, discourtesy or pettiness raise their heads they should be promptly torn up by the roots; all of this to the end that life may be happier and useful and that those who live and work with us may enjoy the

sweet atmosphere of compatibility without which no institution, especially a hospital, can function properly.

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### VOTERS DOUBTFUL OF PUBLIC GENERAL HOSPITALS

HOSPITALS maintained by taxation, except state hospitals for mental patients, are rare. Optional laws, giving counties and cities authority to levy a tax for the erection and maintenance of general hospitals, have not produced marked results. The special tax for tuberculosis sanatoriums has not proved satisfactory and few counties have taken advantage of it in the states which have made them possible.

The public is willing to levy taxes for many other purposes, some of which are not to be mentioned in importance with good health. Taxes for school houses are easy to raise. In the rural sections optional taxes for township and community high schools and for transportation of children to and from school are making rapid headway. Optional taxation to erect memorials and monuments to soldiers is not meeting with much opposition. People pay willingly to support water works and then continue to use wells. They pay for sewers and continue to use the detached open vault. Pavements are an essential, yet they are built by special taxation. For all of these things there are always those ready to take the lead, circulate the petitions for property owners to sign and agitate interest until sentiment for them is on the ascendancy.

But hospitals and other health promoting or conserving forces lag.

There are several reasons.

First: County and city management of charities or charitable institutions, among which we class welfare agencies, hospitals and dispensaries, has, generally speaking, been a failure. They have been legitimate political spoils. Administrators and employees, contractors and service have all been of the same political complexion as the faction in power.

Untrained and often very ignorant men and women have been chosen to manage them, with the result that they have been inefficient, distrusted and generally a stench in the public nostril. The story of our poor farms, county jails and orphan asylums which are supported by taxation is one long, disgraceful, inhumane, almost unbelievable record. Public interest in them has fallen to a low ebb which pleases the political control.

When someone broaches the subject of a city or county hospital at public expense, the public

at once recalls its many unsuccessful enterprises of a social welfare character. The people refuse to have anything to do with it.

A second reason for this apathy is the attitude of the medical profession.

As soon as the subject of a county hospital is mentioned, the factional differences and professional jealousies of the fraternity jump to the fore. The public sees the profession, which should be a unit, divided and it keeps hands off.

It is to the disgrace and humiliation of the profession that it must be said some of its members have always been found mixed in the politics which have ruined the county farms, jails, public dispensaries and the like. The political doctor is ready to take his profit from his political affiliation and will not raise his voice against practices which he knows are wrong.

The county sanatorium for tuberculosis is gradually slipping into the slough of political control. Though the law creating this institution hedges it about with certain safeguards, the small fry politicians look with greedy eyes upon it. They run the jail, county farms and children's homes for their personal and party benefit. They see no reason why the tuberculous should be exempt. So they harness on with certain unscrupulous and unprofessional medical practitioners and by slow degrees they secure mastery of the institution.

Local public opinion is circumscribed by personal interest. There is no organization or group in the smaller community which can or will lead sentiment and prevent the outrage.

Thus the voter is not interested in extending the patronage and working field of crooked or corrupt politics and he votes down the county or city hospital plan.

No one can blame him.

### APPOINTMENT SYSTEMS IN CLINICS

THERE seems to be no subject in out-patient work today which is occasioning more inquiry than appointment systems. The crowding of patients and irregularities of service which have been so characteristic of most out-patient departments and have been the source of such frequent complaint by administrators, physicians and the general public, have naturally caused all concerned with clinics to turn with interest to a promising remedy.

In a number of institutions which have established appointment systems great benefit seems to have resulted. The Presbyterian Hospital out-patient department and the Cornell Pay Clinic in New York, the Children's Clinic of the New Haven Dispensary, and the out-patient department of

the Children's Hospital in Boston, are among current examples.

Miss Thornton's article in the June issue of THE MODERN HOSPITAL (page 596) called attention to dangers which those considering the establishment of appointment systems should avoid. The administrator of a large out-patient department receiving three hundred or five hundred patients a day may propose to establish an appointment system, as if this merely meant the installation of a few simple record forms and telling patients the hours when they are to return. If the appointment system is tried in such a clinic on such a basis, disappointment is likely to result.

As Miss Thornton shows, *an appointment system necessarily means organization of the time factor throughout the clinic work.* This requires that doctors, as well as patients, nurses, social workers, clerks, and administrators must have a time schedule in mind.

Another vital question is that of cost. A clinic inadequately provided with administrative or clerical service, and running hit or miss in the old fashioned way which was once thought the only way a clinic could run, is unfertile soil for the appointment system. The system cannot be established at all without improving the clinic along other lines at the same time. All this requires additional personnel. If Miss Thornton's estimate is correct that an appointment system in a fair-sized clinic takes about one-eighth of the time of the clinic secretary or clerk, leaving about seven-eighths of her time for other clinic service, it is evident that in a clinic already fairly well staffed and organized the extra cost of an appointment system is small. It is also evident that in a clinic which is running along the old primitive line, the entire additional cost of clerical and administrative assistance to the doctors should by no means be charged to the appointment system.

### HEALTH EXAMINATION MOVEMENT SHOWS STEADY INCREASE

Responses to a letter sent out recently by the National Health Council to a selected list of physicians throughout the country indicates a steady increase in the number of persons who are applying for health examinations. It is estimated that during the past year nearly a million examinations were made.

The health examination movement is being urged particularly at this season as a vacation health measure and precaution, owing to the fact that many people during the summer enter into a more or less radical change in living conditions, habits, food, water, exercise, exposure, creating an unusual or different physical or mental reaction. This emphasizes the need of approaching the vacation period with a full knowledge of one's latent powers and limitations.



## ANNOUNCING OUR NEW DEPARTMENT OF FIRE PREVENTION

OUR March number commented on the destruction by fire of one of the buildings of the Chicago State Hospital, for the mentally ill, at Dunning, Ill., which occurred in the closing days of December and caused the death of eighteen persons. Spontaneous ignition of mops and defective electric wiring were given as possible causes of the fire.

For a long time we have been investigating common causes of hospital fires and are convinced that the majority of them are due to preventable causes and, with reasonable precautions and proper safeguards, can largely be avoided.

The number of hospital fires that occur in the course of a year is astonishingly large. The Honorable W. N. Van Camp, insurance commissioner of South Dakota, asserted in a recent address that an average of one hospital fire occurs each day. What this means in loss of life and property he refrained from saying. But the loss is appalling.

Why do hospital authorities allow this to go on from year to year? Is it because they fail to give thought to guarding the property intrusted to their care, or is it because they are not familiar with the dangers so well known to expert fire prevention engineers? We believe the latter is the case. Consequently we have decided to inaugurate a fire prevention department and are pleased to announce that this department will be in charge of Mr. W. M. Krieger, a fire prevention engineer of high standing. This department will begin with the September issue, at which time Mr. Krieger will outline its purpose in some detail.

The great advance made in fire prevention during the past few years is nothing less than marvelous. Among other things, the movement has resulted in the establishment, in various schools, of courses in fire prevention engineering. The graduates of these courses are saving thousands of lives and the loss of thousands upon thousands of dollars by placing before property owners the actual fire dangers that exist in buildings, and by securing the elimination of these dangers. Better still, they are bringing their knowledge to bear on the construction of new buildings with a view to eliminating or reducing fire hazards. It is proposed to place this knowledge and service at the disposal of the readers of THE MODERN HOSPITAL.

Through the department of fire prevention we shall provide hospitals which wish to avail themselves of this service the best engineering talent for a thorough inspection of their buildings, pointing out defects and dangerous fire hazards, with a view to reducing serious loss of life and property. This engineering group will include not only the engineer in

charge of our department of fire prevention but also the volunteered service of the best engineering experts of a number of substantial insurance companies.

In this connection it should be borne in mind that under the universal system of schedule rating, hospitals are charged in their insurance premiums for structural defects and dangerous fire hazards which, if pointed out and corrected, will result in a definite reduction of premiums. But, after all, reduced premiums are a small matter when compared to the possible saving of lives.

Through this department we shall endeavor to give hospitals advice on their insurance coverage, policy contracts and other insurance features, so that they will receive the full benefit of the premiums they pay. Moreover, this department will be glad to give hospitals information regarding the efficiency of any proposed fire-preventive, fire-resistive or fire-fighting appliances, based upon the tests and recommendations of the Fire Underwriters Laboratories, an institution operated without profit and devoted entirely to determining the fire resistance of building materials, steel columns, fire doors, wire glass and various fire-preventive and fire-fighting devices, including electric equipment, heating, lighting and other devices.

It is not the intention of THE MODERN HOSPITAL to engage in the insurance business; on the contrary, we believe in the principle of supporting the local insurance agencies in each community and it will be the purpose of this department to extend its fire prevention service to hospitals without interfering with their present agency arrangements and without charge to either. We are inaugurating this department because we are convinced that there rests upon the shoulders of hospital authorities a moral responsibility to see to it that neither life nor property is destroyed by failure to use reasonable precautions and proper safeguards, and we desire to help hospital authorities to meet this responsibility and assist in the preservation of life and the property devoted to the care and treatment of the sick.

## JUDGES OF PRIZE ESSAY CONTEST ANNOUNCED

**S**INCE the first announcement of THE MODERN HOSPITAL'S prize essay contest in the June issue of the magazine the steady stream of inquiries from hospital and public health workers throughout the country indicates widespread interest in the subject matter of the essay and enthusiasm on the part of the prospective participants.

Six weeks remain for prospective contestants to register their intention of participating in the contest, as all who desire to submit essays in the competition are to register their intention on or before September 15, with the contest editor, at the Chicago office, 22 East Ontario Street, Chicago, Ill. Three months are thus left for submitting essays which are to be in the hands of the contest editor by November 1.

With this issue of the magazine official announcement is made of the committee of award consisting of three outstanding leaders in the hospital and public health field. They are:

Dr. Haven Emerson, professor of public health administration, Columbia University New York, N. Y.

Mr. Michael M. Davis, Jr., executive secretary, Committee on Dispensary Development, New York, N. Y.

Dr. Willard C. Rappleye, superintendent, New Haven Hospital, New Haven, Conn., and professor of hospital administration, Yale University, New Haven.

The committee of award has submitted the following suggestions as a further guide to those who intend to enter the contest.

The committee of award will not be inclined to rate highly an essay which merely elaborates a general principle or a philosophy of hospital and health service. It is well that essays include a statement of principles, but it is essential that the principles be embodied in a plan illustrating

the interrelationships of hospital and community. The facts regarding both the community situation and the hospital and health situation should be presented in sufficient detail so that the committee can form a judgment as to whether the plan offered is sound in principle, and is appropriate for the community or communities to which it is proposed that such a scheme of hospital service would apply.

Essays may deal with a particular size and type of community, or may present a plan and show its application, with necessary modifications, to various types of communities. Size of community will not be a factor in influencing the committee's judgment. A county or a small village may be as important, from this point of view, as a large city.

The committee will not award a prize or an honorable mention to an essay which does not, in its judgment, reach a satisfactory level of excellence, irrespective of its relative rank.

A synopsis giving the salient points of the essay, not exceeding five hundred words in length, is desired.

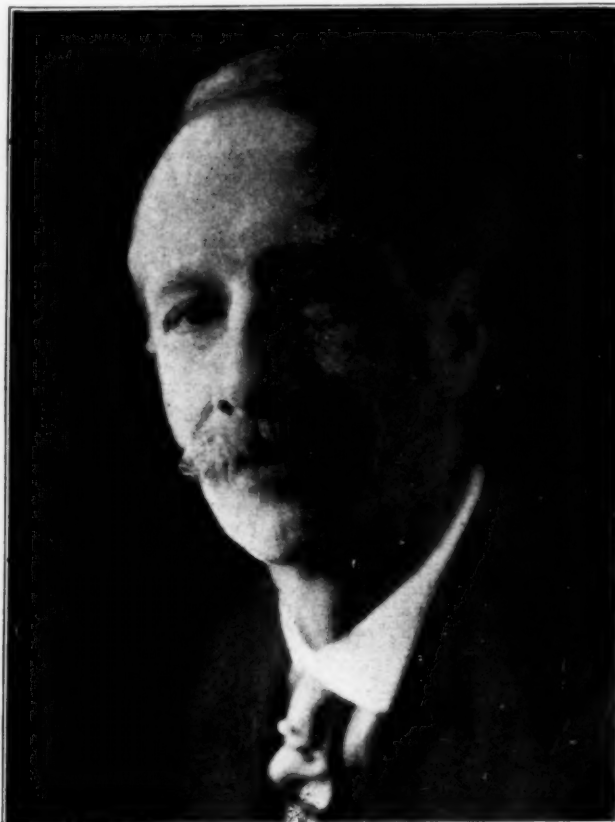
The following five important interrelationships of hospital

and community should be kept in mind by contestants:

### Five Important Interrelationships

Relationships of the institution to—

- (1) Types of cases to be cared for from the medical point of view, e. g., ambulatory, bed, curative, preventive, medical, surgical, etc.
- (2) Economic and social classes to receive care.
- (3) The local medical profession.
- (4) Financial support from operation of institution, from endowment, or from community sources.
- (5) Public health work and social services.



Dr. Haven Emerson, chairman of the committee of award.



## RECENT HOSPITAL DECISIONS

By DOROTHY KETCHAM, ANN ARBOR, MICH.

**Estate Used as Donor Intended When Will Was Made**

Edmund A. W. Hunter died in 1895 leaving a will dated 1893 which was probated. According to the will the residue of the estate was turned over to certain trustees to establish a department of clinical surgery in connection with the University of Pennsylvania. His provision, however, was conditioned upon the university's furnishing land convenient to its hospital as a site for the building. The university, however, failed to make this provision during the lifetime of the trustees and the fund was awarded to the University of Pennsylvania to carry out the charitable use originally contemplated by the decedent. The case was brought before the Supreme Court of Pennsylvania by certain legatees of the daughter who stated that the provision made for the medical school violated the rule against perpetuities and, among other things, that the conditions of the will had not been regarded by the university.

The Court, on February 11, 1924, pointed out that it is a "fixed purpose of the legislature to protect and conserve charitable bequests, though in conflict with the rule against perpetuities, unless the same are void for uncertainty, or, the object of the trust be not ascertainable, or has ceased to exist, . . . in which case the estate reverts to the next of kin . . ."

This rule does not ordinarily apply to gifts made to charity because of express directions to the contrary but "if the clearly expressed purpose of the testator can be accomplished his desires will be followed though new trustees are required, or the funds, by reason of altered circumstances, must be diverted to other like purposes, under the cypress doctrine, though the new use could not be said to express the exact thought of the donor."

"Here, the trustees named in the will were dead, but this did not prevent a substitution, under the legislation, applicable, and the estate had vested for a charitable purpose, whether ultimately carried out in the building of the University of Pennsylvania, or elsewhere.

"The failure, therefore, of the former to comply strictly with the provision for setting aside a piece of land for building purposes did not preclude the court from ordering that the fund be used in the way most likely to effectuate the intent of Hunter . . ." *In re Hunter's Estate* 123 Atl. 865.

**Charitable Property Not Exempt from Special Assessment** In 1915, the village of East Grand Rapids caused a sanitary sewer system and disposal plant to be built, costing about \$50,000. The council decided that forty per cent of its cost should be borne by the property in a special assessment district and the rest by the village at large.

The Union Benevolent Association of Grand Rapids is chartered by law as a benevolent and charitable institution. It erected a hospital building on land owned by it in the village in 1915 which land was included in the special assessment district. The property valued then at \$250,000 was placed on the assessment roll and the tax paid. In 1916 the valuation was increased to \$600,000 and the tax again levied, but not paid. The property was then listed as for sale for delinquent taxes and the question came to the Supreme Court of Michigan March 5, 1924, as to whether or not the property was tax exempt

under the general exemption of real estate owned and occupied by "benevolent, charitable, educational and scientific institutions incorporated under the laws of this state, with the buildings and other property thereon while occupied by them solely for the purposes for which they were incorporated . . ."

It is conceded that the association is exempt from all ordinary taxes but the question of exemption from special taxes is raised here. The court points out "that a tax levied for the benefit of the tax-payers of a municipality as a whole is a general tax . . . There is a clear distinction between what are termed general taxes and special assessments. The former are burdens imposed generally upon property owners for governmental purposes, without regard to any special benefit which will inure to the tax payer. The latter are sustained upon the theory that the value of the property in the special assessment district is enhanced by the improvement for which the assessment is made."

The village councils are authorized to establish sewers and to provide that the expense thereof "may be paid by general tax upon all the taxable property in the village," or by special assessment upon property in proportion to the benefits resulting thereto, or a part may be defrayed by special assessment and "the remainder may be paid by general tax." The court points out that the council determined that sixty per cent of the cost should be paid by a general tax." As to this percentage, the property of the association receives no benefit not enjoyed by all the property in the village. The legislature, in its wisdom, exempted it from general taxation, the tax levied upon it cannot be sustained." *Petition of Fuller* 197 N W 552.

## THE HOSPITAL AS THE PROVING STATION OF MEDICAL PROGRESS

The hospital has another vital function to perform, and that is to enrich medical science by the observations carried on in the institution by men equipped to try out newer methods of diagnosis and treatment on a scale that is impossible in private practice. Were it not for the hospital no progress in medicine would have been possible. It is the proving station, and the research laboratory of scientific medicine. The wealth and variety of material, the organization, the special equipment, all make it possible to study disease as it cannot be studied in private practice. Any hospital that fails in this most vital function pays for its failure by being cast into obscurity.

When a hospital in a community, large or small, has only a local reputation; when it is known only by the patients who have been treated; when it appeals to the local profession on the commercial side only; when, in short, it is merely a well-equipped nursing home, it is a sure sign that the management and the staff have failed to develop the scientific side of the institution.

The true yardstick by which the efficiency of a hospital should be measured is not the number of operations or the attendance on clinics but the number of cases that have been carefully studied and the contributions to medicine which the staff has made.—*The Atlantic Medical Journal*.

## A CLINIC ON HOSPITAL REPORTS\*

**B**EFORE considering the "cases" that have been referred to the present clinic, a review of certain recommendations of the committee of the American Hospital Association on hospital forms pertaining to annual reports is desirable. After discussion of the general purposes to be served by annual reports the committee says:

"A review of a large number of annual reports prompted the suggestion that, if they are to serve the purposes of publicity, more attention must be paid to their compilation in order to improve their attractiveness and promote their appeal. The following points are worthy of careful consideration: (1) size of page; (2) individuality of cover; (3) typography; (4) arrangement of contents; (5) liberal use of illustrations, showing various activities." (Bulletin No. 50 of the A. H. A.)

The director of the clinic, also, after reviewing a large number of hospital reports has reached the same conclusion as the committee and wishes to record his opinion that the points regarded as "worthy of careful consideration" by the committee have not by any means been over-emphasized. That bright and helpful magazine, *Better Times* (100 Gold Street, New York City), which has as its aim the promotion of better community understanding of public welfare problems, has this to say about the reports of welfare agencies "How many hundreds have we seen with drab funeral covers that fairly exuded pessimism before they were opened . . . . In these days of multiple presses so much printed matter is thrown at us that it becomes necessary to make a selection. And the average person will notice and read what is presented in an attractive form, and will push all else aside."

The two reports reviewed in this issue of THE MODERN HOSPITAL present certain features illustrative of the above thought.

### Clinical Notes

#### Case No. 11—(A General Hospital)

This is the 120-page report of a hospital of high standing in one of the large cities of the East. As we shall note later, the report serves unusually well the "purposes" of an annual report as have been set forth in the report of the committee to which reference has been made. But because the report makers have not given due consideration to the compilation of the report in order to "improve its attractiveness and promote its appeal," the examiner ventures to say that if this report were one of many presented to Mr. Average Reader for his review, it would be pushed aside for some other report outwardly more appealing. The very size and weight of the report are against it. It would not be fair to say that its cover "exudes pessimism" because it is a dull and characterless blue, but certainly this blue cover with its plain black title discourages interest. As one skims through it, as Average Reader does before beginning careful reading, the eye fails to light upon anything in type that stands out conspicuously. The illustrations are fine and well selected, but there is a deadening monotony of type and "set up."

This particular hospital has personality; it is in every sense a hospital of distinction, rendering a great com-

munity service. The story of its work is worth reading and the report has much in it that is helpful and stimulating, not only to professional workers but to laymen generally. The report of its board of trustees shows that the hospital policy is progressive and that the board is keenly alive to the hospital's community relations and responsibilities. The report of the superintendent is an excellent presentation of hospital needs, aims and methods. The statistical summaries are good and comparable with those of other similar institutions. The report of the social service department is usually complete and convincing as to the importance of this feature of community service. As a catalogue of hospital personnel and an acknowledgement of the contributions of workers and friends, the report is all that could be desired. But in spite of these many merits the report lacks appeal. It is believed that this defect is one that can be easily and simply remedied merely by improvement in its cover, and the typography and the layout of its contents. If it could be reduced in bulk, that perhaps would help, as 120 pages seem over-long. A better arrangement of material, the avoidance of duplication of discussion and brevity of statement would, it is believed, have added to the report's publicity value.

To make a report readable and to ensure its being read, at least to ensure that its high lights shall not be missed, the judicious use of "side heads" is recommended. The side head should be in different type, or in the same type but more heavily leaded, and should summarize in a sentence or phrase the content of the paragraph. For example, in the report under discussion, the need of an extension of the nurses' home to eliminate overcrowding is referred to only casually in several places, although it is apparently a considerable handicap to the efficiency of the nurses. If this subject is important enough to be emphasized, emphasis could have been given it by the simple device of a side head which summarized the need and focused the attention of the reader upon it, as "A Better Home for Nurses Urgently Needed." If, as appears, the hospital authorities wished to emphasize the hospital's special facilities for the treatment of needy diabetic patients in their homes, a paragraph with such a side head as "Home Treatment for Diabetics Now Offered by the Hospital" would perhaps have stirred the reader's interest. As one becomes expert in "head-lining," the experience gained in thus summarizing themes is conducive to brevity and incisiveness.

#### Case No. 12—(A general Hospital)

As a contrast in outward appearance, at least, to the report just reviewed, we have the report of another large general hospital in another large eastern city. This report has an unusually attractive green cover with its title in black and white. At the top of the cover all the way across the front and back is a panoramic view of the beautiful hospital and grounds reproduced in pleasant green tones. No reader of reports, having this report among a number of others with their "drab colored funeral covers," would hesitate long in deciding which to take up first. The impulse to size the one with the eye-refreshing green cover would be irresistible.

### Attractiveness—A Keynote

Within, the report shows similar evidence of a purpose on the part of the report maker to catch the reader's eye. The arrangement is good, the type is clear-cut and

\*This is the fifth clinic on hospital annual reports conducted by Dr. Carl E. McCombs, New York Bureau of Municipal Research. In this clinic two reports are treated.

"Securing Popular Support," by Theodore W. Hanigan, Financial Secretary of the Brooklyn Bureau of Charities; *Better Times*, May 1922.



of proper size, side heads have been well used to set off the significant features of the reports of the various officers, and there is a continuity of development of report content that carries the reader along smoothly. As a suggestion to other hospital superintendents the side heads used in the report of the school of nursing are worth reproducing. After a brief introductory statement the superintendent of nurses discusses briefly but satisfactorily the work of the school under the following side heads: housing facilities, the curriculum, increase in size of school, hours on duty, social activities in 1923, community cooperation, our hopes for the future, graduated in 1923 (list of graduates). The reports of the superintendent and other officers are presented in much the same manner. The entire report covers only forty-one pages, and can be read from cover to cover in twenty minutes. A page index in the forefront adds to its usefulness.

In this report, however, as in the report previously discussed, statistics of the diseases or other pathological conditions treated in the hospital, and detailed analysis of the results of treatment have been omitted. This is quite in line with the recommendations of the committee of the American Hospital Association on annual reports previously quoted. The committee holds that in view of the fact that existing systems of medical nomenclature are not sufficiently comprehensive and also lacking in uniformity, the publication of professional statistics is inadvisable until a standard medical nomenclature has been developed by the agencies most concerned. What the committee says of medical nomenclature is true and yet, if hospital reports are to contribute as they should to an understanding of the health status of the community, such statistics cannot be omitted without loss. The examiner, at least, would prefer to have such statistical summaries, even if they were not precisely comparable or sufficiently comprehensive. Their lack of comprehensiveness and comparability would not render useless statistics of venereal disease, tuberculosis, typhoid fever, malaria, pellagra, diseases of children, nervous and mental states, occupational diseases, industrial accidents, injuries and the like. Information on these matters is really needed for the purposes of public health administration, and for an interpretation of many of the important problems of social welfare.

#### Statistics of Diseases Prove Valuable

In the writer's recent study of health conditions in a southern city, the lack of adequate statistics in the health department as to disease conditions in the community would have been a serious check upon the development of a rational disease prevention program but for the fact that the one general hospital of the city had, for many years, published in its annual reports complete and detailed analyses of disease conditions found among patients. Prevention of pellagra from which there were a large number of cases and several deaths annually, in the hospital although no cases were reported to the health department except at death, was clearly a most important phase of public health service. Similarly, syphilis, a disease not reported to the health department, showed, in the hospital reports, a high incidence and mortality, and tuberculosis, about which little information was available anywhere except in the hospital reports, was there revealed as a most alarming menace to community health.

In the report now under discussion, there is no information whatever as to the nature of conditions cared for in the hospital proper. Although there were 171 pa-

tients cared for in the communicable disease department, representing twenty-six "different" diseases, no information is offered as to what these diseases were or what the results of treatment were. Certainly the statistics of communicable diseases would be useful in comparing the results of communicable disease care in departments of general hospitals with the results in special isolation hospitals. It would be interesting to health workers in this very city to know whether the general hospital was getting better results in its communicable disease service than were obtained by the health officer in his municipal isolation hospital.

#### Standardized Nomenclature Needed

If a complete, new and thoroughly standardized system of medical nomenclature for hospital report use is necessary, as it seems to be, the writer urges that the matter be given prompt consideration by the American Hospital Association, the American Public Health Association and the American Medical Association. We are informed that certain tentative schedules for reporting statistics of disease by hospitals have been prepared, but as yet not formally promulgated. For public health purposes we now have a satisfactory nomenclature in the International List of the Causes of Death used by the United States Bureau of the Census in its mortality reports and by vital statistics registrars everywhere. A condensed system of nomenclature for hospital purposes comparable to this would be of the greatest value to health workers, and it would help to make effective that desired "inter-relationship of the hospital and community" to which reference has been so many times made in these clinics and elsewhere in the pages of *THE MODERN HOSPITAL*.

#### FACILITIES FOR GENERAL TREATMENT NEEDED BY MENTAL HOSPITALS

Never more than the past year have we been impressed with the mental hospital's need of general hospital facilities and methods in addition to our own special armamentarium. We find among our present population one case whose mental disorder we believe to be based upon an underlying tuberculosis of the lungs; another based upon our concomitant with diabetes mellitus; another pernicious anemia; another hyperthyroidism; another, disease of the pituitary gland and many with at least concurrent disorders of heart, lungs and kidneys. Thus, we realize we cannot too rapidly extend the accepted methods of complete physical investigation in a great number of our patients. We must do this, however, without losing sight of the fact that many individuals with the same diseases show no mental symptoms, and realize that with our patients we are dealing with individuals whose nervous system is their point of low resistance which reacts unfavorably in the face of any stress and strain be it from without or within.—*Eightieth Annual Report of Butler Hospital, Providence, R. I.*

#### MARION CITY HOSPITAL HAS FREE CLINIC

A free clinic sponsored by the Marion County Federation of Women's clubs will be established in the basement of the Marion City Hospital, Marion, Ohio. Physicians will cooperate by donating their services three days each week, working in shifts covering a period of three months. The estimated cost of maintaining the clinic will be \$3,000 a year. The movement is said to be supported by the medical society of the county and other civic and fraternal organizations.

## NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,

2040 Stearns Road.,  
Cleveland, Ohio.

### SIX THOUSAND ATTEND JOINT BIENNIAL NURSING CONVENTION AT DETROIT

SIX-THOUSAND nurses from all sections of the United States and a few representatives from foreign countries attended the joint convention of the three national nursing organizations—The American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing, held in Detroit, Mich., June 16-21. The meeting was the largest assembly of nurses which has ever convened.

The formal opening took place Monday evening, June 16. Special programs were provided for this occasion and a song of welcome was sung by the student chorus from Detroit training schools.

This chorus added much to the pleasure of many meetings and deserves a generous share of appreciation and thanks.

The Very Reverend Warren L. Rogers, dean of St. Paul's Cathedral, Detroit, gave the address of welcome, Miss Adda Eldredge, president, American Nurses' Association, responded. Her remarks may be summarized in the following quotation: "We nurses have but one aim, we ask but one question—where and how can we give the most service, bring about the greatest good?" Other responses were made by Miss Laura R. Logan, president, National League of Nursing Education; Miss Elizabeth G. Fox, president, National Organization for Public Health Nursing; and Miss Clara D. Noyes, director, American Red Cross Nursing Service.

The speaker of the evening was the Honorable John H. Clarke, former associate justice, United States Supreme Court. His topic was "Woman's Relation to World Peace." "Mere man cannot settle this great problem of war. Now that they have the power of the franchise, women may save the world from this greatest scourge," Mr. Clarke said.

"I am not an extreme pacifist and I realize that under present conditions it is possible for any nation to become involved in war at any time. However, the World War has brought into being institutions which, if properly used, would make future wars impossible and I am frank to say I believe the United States should enter into these institutions.

"Christianity and war cannot survive side by side. One or the other must go. Christianity cannot possibly survive another world war."

The program planned for each day included several joint sessions with the members of all three organizations in attendance. It also included section meetings and

round tables for the members of the three organizations so that several section meetings and round tables were in progress at one time.

#### Cooperation of Physicians Needed

At the general session Tuesday morning, Dr. Charles D. Lockwood, attending surgeon, Pasadena Hospital, Pasadena, Cal., spoke on "The Role of the Physician in the Education of the Nurse." If nurses are to be judged by their friends and supporters in the medical profession, we have much reason to be proud of Dr. Lockwood's friendship. His ideals for the education of nurses leave nothing to be desired, unless it is that a larger number of medical men might share them. Just a few sentences taken at random will, perhaps, serve to indicate the trend of his paper.

"The attitude of most physicians is that the nurse is working for him instead of with him."

"Sympathetic understanding and cooperation should be his attitude."

"Many physicians have failed to keep in touch with the progress of nursing."

"Physicians should teach the spirit of scientific medicine to nurses."

Dr. Lockwood's sympathetic understanding of nursing problems did not blind him to its limitations, and his challenge to us was to stand up to our critics and take our medicine when it is deserved.

At the afternoon session Dr. Charles P. Emerson, dean, Indiana University School of Medicine, spoke on "Communicable Diseases." This address alone was worth the trip to Detroit to hear. It was a simple, forceful, direct statement of the problem of controlling communicable diseases and Dr. Emerson put the responsibility squarely up to each individual, stressing the need for such early education in health habits as will make each human being a safe neighbor. In view of the present smallpox situation in some state, it would seem impossible to evade the very strong implication that somewhere, somehow, someone has blundered in a very selfish fashion.

Wednesday morning, Miss Elizabeth A. Greener, superintendent of nurses and principal, school of nursing, Mt. Sinai Hospital, New York, N. Y., presented a very able paper entitled, "A Study of Budgets for Schools of Nursing." This paper appears on page 123 of the magazine.

The afternoon session on Wednesday was given over to government nursing service.

Two important addresses were delivered at the general



session Wednesday evening—one by Dr. Christopher G. Parnall on "The Responsibility of the Community and the Hospital in the Establishment of Nursing Schools." This will appear in a later issue of *THE MODERN HOSPITAL*. The second paper by Mrs. Chester C. Bolton Jr., on "The Responsibility of the University School of Nursing to the Individual Student, the Hospital and the Community," will be published in the *American Journal of Nursing*. Both will repay careful reading. Mrs. Bolton was in regular attendance at the meetings and several times voiced a plea that nurses should take the public into their confidence, should share their problems with the public, particularly that portion of the public that serves as trustees and managers of hospitals and schools of nursing. The urge of Mrs. Bolton's plea was enhanced by her intimate knowledge of the spiritual, emotional and physical strain to which young student nurses are subjected; her recognition of the complex demands made upon the hospital authorities; and her equally clear recognition of the needs of the community. It is safe to assume that with such knowledge Mrs. Bolton and her co-workers will do all in their power to bring about such changes in the schools and hospitals with which they are connected as will make the conditions she deplores quite impossible. Such good results as she can bring about will prove a tremendous factor in encouraging nurses to act upon her plea of sharing their problems with the public.

Thursday morning was given over to section meetings, and the afternoon to a boat ride on the river, made possible through the courtesy of the Parke-Davis Company.

Friday morning the subject of the session was "Meeting the Demands for Community Health Work." The speakers were Dr. Haven Emerson, professor of public health administration, Columbia University; Ella Phillips Crandall, associate general executive, American Child Health Association; and William J. Norton, secretary, Detroit Michigan Community Fund. Dr. Emerson, in his clear-cut style, outlined the essentials in any plan of community health work, and Miss Crandall quoted many instances of intelligent cooperative effort on the part of communities to meet their own needs and solve their problems. Mr. Norton's picture of the problem of the community fund from the standpoint of the secretary of such a fund, was totally different from the picture of the community fund which the principal of a school of nursing in a community fund city is pretty apt to have.

At the Friday afternoon session papers on the university schools of nursing at Yale University and Western Reserve University were presented by the respective deans of these schools. Perhaps the two most important points brought out were that the university school at Yale is an experimental school, and the one at Western Reserve University aims at a community program. It will be extremely interesting to watch the growth and development of these two schools which have so much in common in their aims and ideals and so much that is different in their environment.

The speaker of the evening meeting was Dr. George Edgar Vincent, president, Rockefeller Foundation, New York City, who spoke on "The Public and the Nurse."

The round table on pediatric nursing was conducted by Gladys Sellew, instructor in pediatric nursing, School of Nursing and Health, University of Cincinnati. The discussion centered on the following questions:

(1) The nurse must understand the normal child. How may she be taught to know him?

(2) Can the psychological needs of the child be met by the teacher in a few hours' work upon the floor or must our nurses be taught to care for the "whole child?"

(3) Shall we use our wards or the nursery schools as teaching centers for this essential subject?

(4) Schools of nursing should stand ready to teach the care of the normal child to all groups of women seriously interested in this subject.

The round table on "Adjuncts to Teaching" was conducted by Miss Susie Watson, visiting instructor, Rochester, N. Y. Discussion centered on such subjects as these: planning the schedule, notebooks, excursions, use of wards for teaching purposes, the student as an assistant to the instructor, books and reference readings, use of pictures, and supervised study.

At the instructors' section, presided over by Nellie G. Brown, instructor in Indiana University training school for nurses, Dr. George E. Myers professor of vocational education, University of Michigan, presented a paper entitled "From the Apprentice System to Modern Methods in Teaching." The note of encouragement in this paper was strong because it showed very clearly that nursing is traveling the same pathway from apprenticeship to professional education that medicine, law and theology have traveled.

Miss Isabel M. Stewart, Teachers College, Columbia University, made a most valuable contribution in her paper "Changing Demands in the Preparation of Teachers and How We Can Meet Them." The points emphasized were: value of personality, importance of thorough fundamental preparation, liberal subjects—B.S. degree, application of principles and methods of teaching, must know nursing, also relation of nursing to life, future instructor must know ramifications of nursing work, complete cycle of nursing experience, cannot carry student farther than you have gone.

Miss Margaret Carrington, assistant professor, Yale University School of Nursing, in her paper, "Special Preparation for the Teaching of Nursing," voiced the following recommendations: certificate of standards for teachers in schools for nurses, development of a unified course for teachers, recognized schedule of hours for teachers in schools of nursing, in high schools, twenty hours of teaching is a maximum requirement; in colleges eighteen hours of teaching is a maximum, particularly if teacher is expected to do creative work.

#### Changes Suggested for the Curriculum

At the open meeting conducted by the education committee, the subjects discussed centered about "The Curriculum." Miss Isabel M. Stewart presented a paper on "Changing Emphasis in the Nursing School Curriculum." The limits of space prevent dwelling upon the many challenging aspects of the problem, but mention should be made of the suggestion to increase the preliminary course to five months because it is utterly impossible to crowd the necessary subjects into a four-months' period.

The "Practical Objectives of Nursing Education" published in the April, 1924, number of the *American Journal of Nursing* were discussed from the standpoint of the hospital and nursing school by Sally Johnson, superintendent of nurses, Massachusetts General Hospital school of nursing. From the standpoint of the public health field by Katharine Tucker, superintendent, The Visiting Nurse Society of Philadelphia, who, under the heading, "What the Nurse Does for the Physician," recommended the inclusion of the following: "Observe social factors which have relation to patient's condition, and with the help of the physician, bring about the necessary social adjustments."

From the standpoint of the private nursing field, these

objectives were discussed by Mrs. Janet F. Petersen, president, California State Nurses' Association. Mrs. Petersen represented the private-duty nurses ably and made a plea for the inclusion of their special needs in the curriculum; and for post-graduate courses planned to meet their needs, and not solely to serve the need of the hospital for workers. This was followed by a paper on "Suggestions for the Better Utilization of the Dispensary in the Education of the Nurse," by Helen Wood, chairman of the sub-committee on the dispensary. Miss Wood closed with the following recommendation which was made a motion and passed unanimously. "That some foundation be approached for money to make research work possible in at least two places, with a view to finding out just how the dispensary can be used to the best advantage for the education of the nurse."

The "Transference of Students from One Nursing School to Another" and the "Problems of the Nurse Inspector and What May be Accomplished Through Inspection" were the pertinent subjects for two interesting round-table discussions. Even though the groups in attendance were large, the discussion was lively and to the point.

One section that deserves very special mention was the one on communicable disease nursing, presided over by Alta E. Dines, director, Bureau of Educational Nursing, Association for Improving the Condition of the Poor, New York, N. Y. It was an actual demonstration showing the method used by the visiting nurses in teaching a mother the care of a child suffering from communicable disease. The nurses who acted the part of the mother and nurse did so with keen enjoyment that left a very distinct and worthwhile impression on the audience.

A few very concrete impressions of the entire meeting were: The dominant and repeated emphasis in almost every session for mutual understanding and cooperation of doctors, nurses and the public. This would seem to be a necessary trinity of workers for any effective program for the prevention of disease and the promotion of health. How happy and fortunate nurses would be if they had the wisdom to help even in a small measure to bring about such a trinity.

Former presidents of our national organizations ought to be accorded special privileges and shown special honors. When this is not done, it is often difficult to catch a glimpse of those who have graced former platforms and contributed much to our progress.

A large group of Vassar Camp nurses were in attendance and it was heartening to hear their names coupled with worth while pieces of work.

Another impression is of the emergence of the problems of the private-duty nurse and the necessity for giving them greater consideration than ever before. The progress of all nurses is determined to such a large extent by the intelligent and satisfactory service rendered by the private-duty nurses that we cannot afford to ignore their problems or fail to give thoughtful study to their reasons for discontent.

Daily bulletins and special programs helped tremendously toward the smooth running of a crowded program. The music furnished by the student chorus, by Mesdames Leona E. Mitchell and Helen K. Snyder, by the accompanist, Miss Mildred Johnson and the director, Mr. William Howland, was an enjoyable feature of the meeting.

Good advertising was represented by the booklets furnished by the *American Journal of Nursing* and the *Public Health Nurse*. The exhibits of nursing equipment and supplies were attractive and of high educational value.

The next annual meeting of the American League of

Nursing Education is to be held in Minnesota, and the 1926 meetings of the three organizations are to be held in Atlantic City.

The officers elected were:

*American Nurses Association:* Adda Eldredge, R.N., president; Elnora E. Thomson, R.N., first vice-president; Jane Van de Vrede; second vice president; Agnes G. Deans, R.N., secretary; and V. Lota Lorimer, treasurer.

*National League of Nursing Education:* Laura R. Logan, R.N., president; Carrie M. Hall, first vice-president; Mary M. Pickering, second vice-president; Ada Belle McCleery, secretary, and Bena M. Henderson, treasurer.

*National Organization for Public Health Nursing:* Elizabeth G. Fox, president; Grace Anderson, first vice-president; Jane Van de Vrede, second vice-president. The nurse directors are: Ella Phillips Crandall, Janet Geister, Sophia C. Nelson, Mrs. Helen C. La Malle.

### SECTION ON GOVERNMENT NURSING HELD AT A. N. A. MEETING

A separate section on government nursing services has been organized for the first time in the history of the American Nurses' Association. This section was duly authorized by the board of directors in October, 1923, and the first meeting under the charge of a temporary chairman was held at the Detroit convention Wednesday, June 18, 1924, at a general session. The object of the meeting was to present the various phases of the nursing services that are conducted by the government.

The first speaker was Miss Florence Patterson, who is now director of nursing and field work of the Community Health Association, Boston, Mass., but who formerly was a special investigator of nursing in the Indian Service. The nursing situation in the National Soldiers' Homes was explained by Miss Anna Grace McCrady, superintendent of nurses, National Military Home, Marion, Ind. Miss Clara D. Noyes, director of Nursing of the American Red Cross, told of the close relations between the American Red Cross nursing service and the government nursing services, and referred to the part that the American Red Cross nursing service will play in the test roll call of nurses that will be made on Defense Day, September 12, in connection with the test mobilization of the military power of the country.

An account of the Navy Nurse Corps and its relation to the advancement of nursing, with special emphasis upon the two schools of nursing for the men in the navy was given by Miss J. Beatrice Bowman, superintendent of the Navy Nurse Corps. Miss Lucy Minnigerode, superintendent of Nurses of the U. S. Public Health Nursing Service, read a paper showing very clearly the difference in standards for nurses in the government nursing services, and called upon the section for cooperation in eliminating these differences.

The following day a round table was held at 9 a. m. At this later meeting Mrs. Mary A. Hickey, superintendent of nurses, Veterans' Bureau Nursing Service, read a paper on the present nursing service of the Veterans' Bureau, and what the Veterans' Bureau is doing for disabled ex-service nurses. Major Julia C. Stimson, superintendent, Army Nurse Corps, talked about the nursing service as one of the educational functions of the medical department of the army. The officers elected are: Chairman, Miss Lucy Minnigerode, superintendent of nurses, U. S. Public Health Service; vice chairman, Miss J. Beatrice Bowman, superintendent, Navy Nurse Corps; secretary, Captain Sayres L. Milliken, assistant superintendent, Army Nurse Corps.



## THE THIRTIETH ANNIVERSARY OF THE STANFORD SCHOOL OF NURSING

By MISS MAUDE LANDIS, A.B., R.N., PROFESSOR OF NURSING, STANFORD UNIVERSITY, SAN FRANCISCO, CAL.

THE Stanford School of Nursing, San Francisco, Cal., has celebrated its thirtieth anniversary at the annual Reunion and Commencement exercises, May 14 and 15. Two floors of the school of nursing consisting of the auditorium, class rooms, laboratories, library and reception rooms, were set aside for the occasion.

Since last January plans had been in the making. Over 400 of the 500 graduates had been located and correspondence had been established with 250 of them. Class pictures and souvenirs of the "happy training school days" had been collected, and short histories of the graduates since leaving the school were made accessible in the library.

The instructors of the school prepared an exhibit of the work of the various classes which was displayed in the class rooms and laboratories. This consisted of notebooks on all the courses given during the year, showing the methods of presentation by the instructors and the excellent organization of the material on the part of the students.

The preliminary class had prepared posters illustrating the sources of drugs studied in elementary materia medica. They also dressed a large doll in the Stanford student nurse uniform, even to such details as the string of safety pins and scissors under the apron, the watch and fountain pen in proper places and the uniform pocket full to overflowing with what the present day student finds necessary to have close at hand, the bobbed hair under a net, and the red "S" on the cap.

### Exhibit of Misused Equipment

An exhibit which attracted much attention also prepared by the preliminary class, consisted of a collection of articles misused in the hospital, such as catheters, colon tubes and nipples that had "boiled dry," thermometers, syringes and other glassware that had been broken in various ways, aluminum pans that had been left on the flame and forgotten, linen that had been burned or torn or stained, together with a collection of the great variety of stains to which hospital linen is liable. The members of the junior class had prepared papers, each on a different advanced nursing procedure, and had set up trays or apparatus or had made their own drawings, to illustrate these papers. A pin map had been prepared to show the geographical distribution of graduates and students of the school, and the location even of the preliminary students who had been accepted for the August class.

All these exhibits which created general interest are evidences of the careful attention that is being given to the instruction of the nursing students.

Early in the afternoon of May 14, graduates from far and near assembled in the nurses' residence, to renew old friendships and talk over old times. Official welcome was extended by Dr. Somers, superintendent, Lane and Stanford Hospitals, Doctors Stillman and Cheney, members of the early day training school committee, Miss Vogelgesang, president, Lane-Stanford Nurses' Alumnae Association, and Miss Landis, superintendent of nurses.

### Recounts Thirty Years of History

Dr. George B. Somers gave an interesting history of the development of the school from the early days when

the "lady cook" received a higher salary than the "head nurse," through the periods of transition when the student nurses first lived outside the hospital in a home of their own; when the course of study was gradually lengthened and strengthened to meet educational requirements; when the training school with the medical school and hospital was taken over by Stanford University, to the present day, when the Stanford School of Nursing has its own nurses' residence with an educational department erected at a cost of \$450,000 appropriated by Stanford University. Miss Landis outlined the educational policies of the school. Thus early and recent graduates became reacquainted with their alma mater and united in common interest and loyalty.

The reunion banquet was held in the evening, at the Palace Hotel, under the auspices of the alumnae association. One hundred eighty-seven graduates who were in attendance were seated by classes. Class 1924 numbered thirty-nine members. Throughout the dinner there was orchestral music, interspersed with class and school songs. After-dinner speeches reminiscent of the school at its beginning, the first operating room, the organization of the alumnae association, the fire and earthquake of 1906, the mobilization of Navy Units No. 2 and No. 11, the Mobile Operating Unit No. 1, the hospital during war time,—revived old enthusiasms, and talks of what graduates are doing at Palo Alto at the hospital there, and at the convalescent home for children widened the perspective of all graduates as to the institution's activities. "Hail, Stanford, Hail" closed a memorable evening.

On the next morning, May 15, from 10 to 12 o'clock, there were trips with escort through the nurses' residence, including the infirmary on the seventh floor, through Lane and Stanford Hospitals, the clinics, the medical school and laboratories, Lane medical library and its new collections on exhibition, and the new special diet laboratory where ambulatory patients may be served prescribed diets without becoming hospital patients.

### Social Aspects of the Anniversary

In the afternoon the members of Class 1924 were hostesses at a tea, during which they presented their class gift to the nurses' residence—a mantle clock with Westminster chimes. At this time there were read cablegrams, telegrams, letters and greetings from nursing leaders among whom were Miss Goodrich, Miss Gray, Miss Logan, Miss Roberts, Miss Hogeman, Miss Muse, Miss Shouse, and from faraway graduates. The Rockies were levelled and the Pacific was bridged. In spirit, Stanford graduates joined hands with eastern and western nurses.

The commencement exercises were the climax of the events of the thirtieth anniversary. President Ray Lyman Wilbur of Stanford University gave an address, full of helpful suggestions of wide usefulness of nurses and the standards for nursing education. The diplomas and pins were presented by Dr. Somers and Miss Landis, as is the usual custom. Music was furnished by the student glee club.

After these exercises, the auditorium was cleared for dancing by graduates and friends. The thirtieth Anniversary has become history.

## DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,  
Supervising Dietitian, Mt. Sinai Hospital, New York.

### HOSPITAL DIETETICS IN RELATION TO COMMUNITY HEALTH PROBLEMS\*

By MISS E. M. GERAGHTY, DIRECTOR OF DIETETICS, LAKESIDE HOSPITAL, CLEVELAND, OHIO.

**B**EFORE attempting the consideration of the relation of hospital dietetics to community health problems, we should have a mutual understanding of our conception of hospital dietetics and of the term community.

It would seem that "hospital dietetics" might be classified as the intelligent coordination and application of many factors dealing with the dietetic contribution to health maintenance.

The term "community" is so well defined in the report of the committee on the training of hospital executives that I am taking the liberty to quote one paragraph—"A majority of the crippling and killing diseases do not lend themselves readily even to the most efficient community control and the attitude in the field of public health is evidently shifting from consideration of the aggregate toward consideration of the individual unit, the home. A large proportion of illness is cared for and should continue to be cared for in the home and the problems, economic and other, incident to illness, often represent major threats of the very existence of this unit, which in the aggregate, constitutes the community and the nation. High-grade health services are available for the rich and poor but provisions are inadequate for bringing the best which modern medical knowledge offers to those of moderate means, who in reality, are the main element of our national life and strength. Any plan of organization proposed to meet adequately the health problem, therefore, must be predicated upon these considerations."

#### The Hospital's Relation to the Home

May we assume, for purpose of discussion, that hospital dietetics in relation to community health problems may be interpreted to be a study of the hospital's responsibility to the home?

The first question to be answered before attempting to outline dietetics in this connection must be "What are the major functions of the hospital?" Having answered this by a consideration of service, education and research we may now investigate our departmental organizations and evaluate each part in its relation to the hospital as a whole.

We must also ask ourselves the questions, "Are we playing the game all the way through?" Before we can answer this, we must know what constitutes the game,

when we may consider the end in view, for whom we are working and with whom we are working. Our individual games are determined by the dietetic ideas and policies of our hospital administrators. We are working with the doctors for the hospitals and the patients. To do this we must know the aims we have in common and toward which we may work with mutual consideration and understanding.

May I present as an objective for our direction of activities better service to patients, better service to hospitals, economic independence of the family and more complete and sustained application of dietetic principles to the treatment of disease and the retention of positive health?

As a vehicle to carry me from the theoretical to the practical end of this material I am going to use a personal experience. Last year I visited the dietetic department of one of our well-known hospitals. I asked the dietitian if the hospital instructed its patients who were receiving therapeutic diets. She replied, "Oh, yes—just before they go home we tell them what to eat and we give them a printed diet list."

#### The Problem of Teaching Patients

Our internists have spent from six to ten years in college, from one to five years in hospital residence and have years of experience. Dietitians have spent from four to seven years in college with from six months to one year in graduate hospital training and added years in the administration of dietetics. Both groups find real problems in the adjustment of available foods to meet requirements imposed by physical conditions and influenced by economic status, racial and religious customs and family responsibilities. Are we justified in expecting these patients to acquire this knowledge in a superficial talk just before going home or from the perusal of a diet list? Are we even seeing our job all the way through if we start instruction the day the patients enter the hospital and continue to give intensive instruction every day of their stay and then tell them to return to the clinic next week? No, most emphatically, no! We need to go further than that.

The patients, while in the hospital, are in an unfamiliar environment, many of them are actually frightened, their mental processes are not normal and they do not see materials in relation to their home conditions. No matter how excellent our instruction, no matter how intelli-

\*Read before the third annual conference of the Hospitals of Pennsylvania, at Pittsburgh, April 2nd., 1924.



gently we have adjusted the diet served to the probable home food habits of our patients, we cannot hope to accomplish a "complete and sustained application of dietetic principles to the treatment of disease and the retention of positive health" unless we give more than temporary and superficial treatment and instruction. Can we, sitting at our desks, visualize the foods and utensils Mrs. Brown will have at home? There is a certain idea of "putting the best foot forward" which often hinders our efforts. Last year one of our diabetic patients told me he had an income of "less than three thousand dollars per year." We planned his meals on a basis of an average family of four on an income of twenty-five hundred dollars. Home visiting revealed a wife who had gastropotosia and was on a restricted diet; one child had nephritis. The income was less than fifteen hundred dollars and only one member of the family could take an unrestricted food allowance.

### The Necessity of Follow-up Work

What is the real group aim? Temporary treatment, the mere service of three meals a day while the patient is in the hospital or is there a willingness to help him come along the path to positive health? Is it our sincere desire to help the doctors in their work? Are we going to indulge in mental inertia or are we going to help the hospital fulfill its obligation to the home?

Sometimes we have to sell the ideas of our policies to our own dietitians. One of our field workers, who had been doing work with cases from the clinics, was asked to call on a woman who had been discharged from the hospital the day before. The dietitian said, "Why, I wouldn't think she'd need a visit so soon. She was in here for over three weeks and had instruction all the time and her thirteen year old daughter came in for instruction several times and she was able to figure the diet out very accurately; she was taught how to give illetin, how to test for sugar and given very extensive instruction about daily allowances in diet. She knows just what to prepare for her mother."

But the dietitian went and upon her return, said, "Well, I'm glad I went out there. I thought it was foolish to go but it certainly was needed. I found house upset and smoky, and the daughter almost in tears. She had attempted to administer illetin but her mother protested with screams. Then she had served her breakfast and Mrs. Reed had refused to eat except a very little. It was not surprising, because the bacon and eggs were hard as could be and the tomatoes were scorched. We cooked some more and the mother ate it all. We worked out the diet for the rest of today, made bran muffins, a dessert, and salad dressing, and then went to market for some vegetables. I'm going again tomorrow morning."

Mrs. Carpenter is one of our colored patients who had difficulty in following a rigid adherence to diet. The first week at home she followed her diet beautifully, made the bran muffins and decreased her output of sugar. At the end of three weeks, she was so confident that she thought she could substitute foods. For the bran wafers she substituted graham crackers as "they look a lot alike." She drank a quart of milk a day because, "I feel so weak and I always heard that milk was very nourishing." We told her she should not take more than we had allowed her. The next visit we found she still showed sugar. She was now drinking buttermilk. "But buttermilk's sour and there can't be any sugar in that." We thought we succeeded in impressing her with the necessity of following our diet allowance. For several

weeks she was sugar-free. Then a visit revealed another output of sugar. "No, ma-am I ain't eatin' nothing 'cept what you-all tells me—no ma'am." A lengthy and apparently casual conversation led up to a query about the patient's general health. "Oh, I'm feeling fine, just like a race horse. I'm taking a tonic every day." When we told her that this "tonic" which contained ten per cent alcohol was probably responsible for her sugar output I'm sure she felt we were determined to deprive her of every joy in life.

### Persistent Vigilance of the Diabetic

But even after the ground work has been done and the patient seems to be getting along famously on the diet and all the family has been won over to cooperate, the dietitian will call some day and find that the patient is tired of the diet.

The diabetic (who probably has always overeaten before he was discovered to have diabetes) will say, "I was so tired of the things you allowed me that I just had to eat a piece of bread." And worse than that, he usually doesn't stop at one piece when he once breaks off. He has lost hold and it is necessary to reason with him, to explain all over again, and give new impetus for staying on the diet. New ways of fixing the same allowed foods or instructions about substituting foods may be the necessary remedy. Sometimes all that is needed to keep the patient on the diet is for the dietitian to let him know that the hospital really cares and that the doctors are interested. In many cases we might be apt to lose patience and think they were hopeless cases when they constantly break away from their allowance. But after a few visits in the homes of the patients we realize the awful struggle they are making; the old appetite may have come back or some one has persuaded them to eat some forbidden food saying that just a little won't hurt, or maybe there is sickness in the home and the patient has forgotten self in anxiety for some other member of the family.

What if there had been no thought except, "Oh, yes, the day they go home we tell them what to eat and give them a printed diet list?"

The president of one of our great universities says to the students, "We finish what we start." Let's be able to say the same of the hospital dietitians.

We shall not reach our goal all at once but I believe we shall arrive sooner if we have a more thorough understanding of the needs of those whom we serve. I believe the doctors will have a finer appreciation of the hospital service if we go beyond our four walls and extend to them our services in their great work. I know the residents of the locality will have kinder thoughts when they know "the hospital really cares about me."

Since the contribution which the hospital, through its department of dietetics, makes to the community is not the ideas and policies of that department but the dietetic ideas and policies of the hospital administrators, the initiative in the extension of this work will have to be yours. It will be a pleasure and a privilege for us to help you.

### MASSACHUSETTS DIETITIANS ELECT OFFICERS

The Massachusetts Dietetic Association elected the following officers at its annual meeting held in Boston, May 23; president, Miss Amalia Lautz, Peter Bent Brigham Hospital, Boston; vice-president, Miss Quindara Oliver, Children's Hospital, Boston; secretary, Miss Effie Riley, R. H. Sterns Employees' Cafeteria, Boston; and treasurer, Miss Margaret McGovern, Boston City Hospital, Boston.

## WHAT THE BUDGET DID FOR THE DIETARY SERVICE OF FLOWER HOSPITAL

BY ESTELLE BARKER, SUPERVISING DIETITIAN, FLOWER HOSPITAL, NEW YORK, N. Y.

**I** CALL myself a "returned dietitian" not because of any overseas service, or because of a recent or remote experience on the foreign missionary field. No, indeed, for all that I know of war is only such as that which staying at home and wrestling with the labor situation might bring; my knowledge of missionary work is decidedly limited to home activities. After nine years of varied hospital work, I felt that more would be too much, in other words, the insulation was worn off. Accordingly, I ventured forth upon a business career. Although this "business flier" was of only three years' duration, that period represents one of the most enjoyable and profitable experiences I could possibly have chosen. Then I returned as unexpectedly as I had left hospital work.

Now, I want to make it plain that I came back with a much keener sense of values, both commercial and human. After having paid my own meat bill at the end of each week, I had a much deeper sympathy with the hospital superintendent who is suddenly confronted with "the largest meat bill we have ever had." Also, I realized that department heads like business people are blind to the neighbor's business only because they are so wholly absorbed in their own. It is not really a lack of sympathy for or interest in the different departments that makes the apparent disparagements and criticisms.

We have just completed the first year, and we feel that our experience may be of interest to others in the profession.

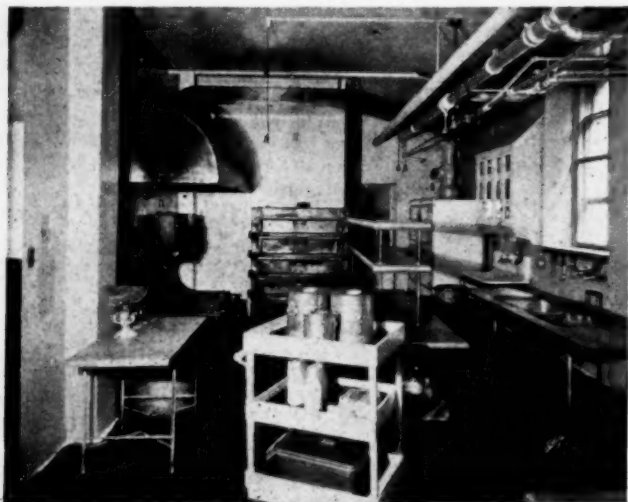
Architecturally, the hospital is not adapted to a central kitchen service. However, with the exception of the special diets one kitchen prepares all of the food. At serving time the food is sent to the different wards in bulk and served from the ward pantries, the trays being set and the tray dishes washed by the ward maids. Hot foods are sent in separate thermostat containers. This is fairly satisfactory, though it is possible that these may be replaced, as they wear out, with insulated food carts.

As the main kitchen is located in the basement of the

private pavilion, a system of centralized food service is used for the private patients. This means that the trays are practically ready to serve when they leave the kitchen. The trays are set up with china, silver, and other appointments, before time for serving the meal, and placed on food carriages. These metal carriages, equipped with shelves, are wheeled into the kitchen at right angles to the chef's table. The chef stands on the range side of the table and the dietitian on the opposite side so that each checks every tray as it leaves. Hot water plates are used for the meat, potatoes and one vegetable. The plates are made of nickel silver with three divisions in the plate section, and fitted with nickel silver covers. These hot water plates are more or less satisfactory; we do not consider them ideal, but as yet there seems to be nothing better on the market. The butter is sent in quarter pound prints to each corridor allowing eight portions per print. The bread for each carriage is cut and wrapped in paraffin paper. The salad and dessert or fruit is placed on the carriage last. In serving ice cream or ices, a separate tray of the ice is sent to each corridor about twenty minutes after the food carriage. Coffee and soups are sent in large pots and kept hot in the serving pantries; from the large pots these beverages are poured into the silver coffee pots and soup cups. Individual tea balls are used for the tea service. As this service includes only regular diets such as house, light, soft and liquid, the service is accomplished very quickly. An average of sixty trays per meal is served in this manner, and the service is completed within twenty to thirty minutes from the time the first hot plate is served.

### Special Diet Kitchen

The diet kitchen which is quite separate from the main kitchen both in location and activities takes care of all classified therapeutic diets. These diets are served as individual trays and are taken directly to the patients, also returned directly to the kitchen for weighing and checking any food that may have been left on the tray.

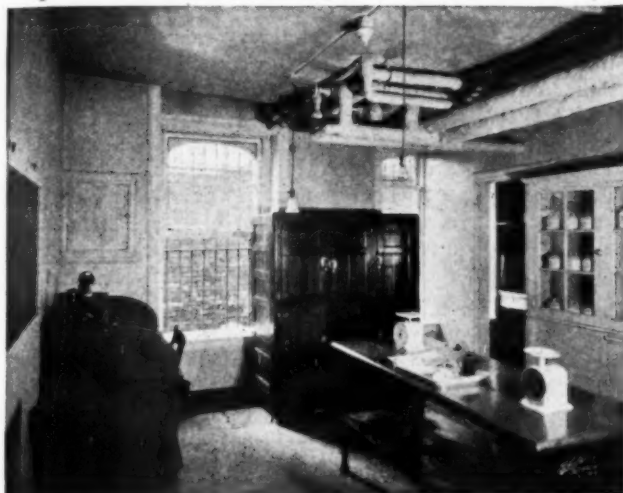


Kitchen annex showing bake ovens. In the foreground is a food cart with thermostat containers and other supplies for ward service.



View of main kitchen showing ranges and steam cookers and food carriage with hot plate service ready to be sent to private corridor.





Special diet kitchen showing range and sink in annex to the right.

An average of fifty to sixty trays are sent from this kitchen each day. All custards, jellies, gruels, and such foods, are sent from this same kitchen.

We have recently started a diabetic clinic. To date the present dietary staff has been able to give such consultation as the physicians have needed. The patients are given individual instruction in the special diet kitchen as it is needed.

The nurses' dining room has waiter service as does also the doctors' and the hospital staff. The nurses' dining room is kept open for service one and one-half hours each meal service. This arrangement provides for the special nurses, attendants, office and laboratory girls to be served at the first meal. The dining room is then closed for fifteen minutes for resetting. This arrangement makes it possible for every member of the training school to have her own plate at a specified table. The employees have an improvised self-service which is satisfactory.

#### Distribution of Supplies

The stock room and retail grocery have been combined so that with the exception of the dry groceries such as coffee, sugar, and such items, the stock is kept almost entirely in case, with only the top case opened. This arrangement suffers the disadvantage of not being as attractive in appearance as the nicely kept show shelves. On the other hand, there is a decided advantage in not having the wares too alluringly displayed. This stock-room is open twice a day for kitchen supplies; ward and private pavilion supplies are requisitioned and issued once a week.

We are supplied with brine refrigeration. The ice-box space is limited to five separate compartments, one is used for milk, cream and fermented bottled milk products, one for butter and eggs, one for meats, one for dessert and fruits and one for general service. Ice-box supplies are issued three times a day with the exception that the oranges, lemons, and eggs are sent daily to the service pantries on the various corridors.

#### Reduction in Food Costs

Though comparisons are odious, the following figures are not quoted in a spirit of criticism other than constructive. It is the office method of drawing up the monthly statement as compared with the same period of time the year previous. The figures which follow include a comparison of two successive years, the latter year hav-

ing to its credit 14,659 additional hospital days. The bed capacity is 252 including infants. The average number of meals per day is 1,150 to 1,200.

The budget system has been an important factor in the savings which we will note. Each department is given an allowance at the beginning of the year. In the dietary department, we make a rough estimate at the beginning of each month, guided by census, time of year, and market conditions, deciding on approximately the amount that may be spent on each one of the seven items in the budget. In some instances, for example, on meats, fruits and vegetables, and dairy products we also make a daily allowance. This is a most helpful factor in steadying the expenses.

#### Reduction in Provisions

Under the classifications designated as provisions are placed all foodstuffs excepting meat and fish. This column gave a total saving for the year of \$2,200 as compared with the year previous. The most interesting reductions were brought about in three outstanding instances:

**Milk:** In changing from "loose milk" to grade B bottled milk for distribution to all patients, we brought about a saving of twenty per cent in total cost. This change has been satisfactory in every way, although it was not instituted with an anticipation of reducing actual costs, but for facility in distribution and for sanitary reasons.

**Butter:** By a guarded distribution of butter calculated on a per capita basis, and by use of butter chips and individual service in the dining rooms in place of the one dish of cut butter on each table, the amount consumed was twenty per cent less.

**Bread:** Sending the bread, cut and wrapped in paraffin paper to all serving pantries decreased the bread bill ten per cent.

Supplies include gas, electricity, soap, towels, linens, paper napkins and such equipment having a duration of less than one year. In this item we practiced a most rigid economy and were credited with a saving of \$1,000.

#### Saving in Meats

A great saving is realized on meats, which are a big item, as we never have fish oftener than once a week, except during the lenten period. Our meats are ordered daily. We buy retail cuts. The meat bill gives us an average of nine to nine and one-half ounces per person per day, and an average cost of fourteen and one-half to fifteen cents per day. If one has the time, weekly trips



Nurses' dining room.

to the fish market are a satisfaction and an economy. However, this is also true of other wares, and not possible in all instances. This method has been used the greater part of the year in question saving from four to ten cents per pound. We were credited with a saving of \$5,581 in the meat column, in spite of the fact that the market price was fifteen per cent higher than the year previous.

The increased cost appears in two columns: one, dietitians' salary, which is accounted for by the presence of a second dietitian; two, labor. This was a matter of \$80, but this sum does not cover the salary of a porter who was added to the force in the special diet kitchen.

### Total Saving of Department for Year

In all there was a saving of \$7,000 credited to the dietary department for the year. An extract from our monthly statement may be of interest. The following covers the first two months of the consecutive years:

	Year to Date, 1924 (Jan. Feb.)	Year to Date, 1923 (Jan. Feb.)	February 1924	February 1923
DIETARY:				
Dietitians .....	\$ 768.65	\$ 533.70	\$ 383.65	\$ 283.70
Cooks .....	1,043.50	728.85	528.65	333.85
Labor .....	2,420.60	2,375.60	1,207.90	1,218.05
Provisions .....	8,791.99	10,389.97	4,306.74	5,292.54
Meats .....	3,167.53	3,853.59	1,592.44	1,935.73
Supplies .....	1,039.16	1,652.85	513.74	664.31
Ice .....	50.00	50.00	25.00	25.00
	\$17,281.58	\$19,584.56	\$8,558.12	\$9,753.18

Per capita costs are figured in two ways. By one method the auditor in making monthly statements divides the total cost of raw food by the number of meals served. By the second method, each article of food issued from the store-room or ice-box is charted at cost. This total is more exact than the first one in the monthly statements, as it leaves no loophole for the inventory bugaboo. In the total for the year these two tally very closely. For the year 1923, the average meal cost was twenty-one and one-half cents, for the first five months of 1924, it is eighteen cents. The average meal cost for private patients at the present is forty cents.

Menu making also has its part in the economies noted. While it is true that making menus for at least one week in advance has its many advantages, I find that for a hospital of medium size in which the planning of meals and buying of food are done by the same person, it is really a greater saving to plan no more than two or, at the most, three days ahead. In this way there is the tendency to use what is at hand instead of ordering what the menu demands. This latter method requires an infinitely greater amount of work, as will be easily seen.

### Duties of Dietitian

The duties of the dietitian include the selection and buying of all food supplies, responsibility of entire food service to the hospital family of about 400 members, instruction of student nurses in cookery, practical dietetics and dietotherapy, a course of lectures to the senior students in the medical college.

The staff includes a supervising dietitian, two assistant dietitians, both of whom are home economics graduates, and a dining room supervisor. We have twenty-six male employees. For a period of ten months, each employee had one whole day "off" each week. This plan was not satisfactory from a standpoint of efficiency and was abandoned. We now give the usual hospital allowance, one-half day a week and one-half of every other Sunday.

A very satisfactory arrangement is that of having one chef and assistant work from 7 a. m. until 6 p. m., and another chef from 9 p. m. through the preparation of breakfast. The latter also prepares and serves the mid-

night supper and makes desserts for the next day. He has one helper who joins the day force at 4 p. m. and works until 1 a. m. This has eliminated much of the former confusion and worry about breakfast.

Cooperation has had a big part in the accomplishments of the year. Without the help of every one in the hospital this work could not have been possible. This spirit has been greatly encouraged and strengthened by the meetings of the superintendent with the heads of the departments. When the monthly statement is drawn up, this meeting is called for the purpose of general information on the intimate workings of the hospital and for constructive criticisms. That they fulfill their mission is self-evident beyond question, for we are admittedly proud of our reports. I say "our" because other departments have also made some interesting savings. This is the story of only one phase of the work.

### OHIO DIETITIANS HOLD THIRD ANNUAL MEETING AT CEDAR POINT

The Ohio Dietetic Association held its third annual meeting at the Hotel Breakers, Cedar Point, Ohio, June 10, 11, and 12, 1924.

The meeting was presided over by the president, Miss E. M. Geraghty. The speaker of the program June 10, was Miss Hughina McKay, assistant professor of home economics, Ohio State University, Columbus, Ohio, who read a paper on "The Education of the Dietitian in College." She said in part:

"The longer I live, the more I study this question of diet, the more I become convinced that if people could be trained from infancy in a rational sensible use of food a great deal of suffering could be avoided."

"Joslin suggests that where diabetes appears to be hereditary as in this case the actual cause may not be heredity but a family diet followed by all the members of the family."

"The same fact may hold with underweight. Parents often object most strenuously when they are urged to try and bring their children up to weight. They say, 'Johnny's father is thin and underweight and Johnny gets it from him.' Now while this may be the case there is also the possibility that Johnny's father is underweight because his food habits are poor and that Johnny is following in his footsteps in regard to food habits and therefore in regard to underweight."

"To put this thought in another way I think we should take food a little more out of the realm of personal likes and dislikes and whims and fancies and put it where it belongs—on a scientific basis."

"Another point we like to emphasize is the preparation of attractive, palatable meals which embody all the essentials of an adequate diet. So often to the lay person the terms 'Well selected meals' or 'balanced meals' means the elimination of palatable foods, a diet Spartan-like in its limitations, with everything one likes excluded and everything one does not like included."

"To sum up then, I believe the dietitian or the nutrition division of the home economics department of the university should aim to include the entire student body in its teaching program. Such a program should include teaching the essentials of diet for the optimal physical condition as well as emphasizing individual responsibility in the use of a rational diet. To reinforce such teaching, food service on the campus should be under the general direction of this division. Above all, because what we believe today is perhaps after all only part of the truth,

(Continued on page 180)



## HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent  
Michael Reese Hospital, Chicago, Ill.

### WHAT THE SERVICE EMPLOYEE SHOULD KNOW\*

By JOHN A. WYLLEY, FOREMAN, GENERAL SERVICE, UNIVERSITY OF CALIFORNIA HOSPITAL, SAN FRANCISCO, CAL.

THE subject of good cleaning is now attracting considerable attention. This has come about with the advent of fine surfaces in all types of equipment, of costly finishes, elaborate fixtures and skillful interior design which have made it an economic necessity to train the employee to clean, and to educate him to a better understanding of the things which he handles, his responsibilities as a custodian and, in the hospital, his duty to the patient.

Good cleaning not only costs less for materials and labor, but it increases the efficiency of other employees by making their surroundings more attractive; it attracts wider patronage to an establishment and increases its prestige.

A knowledge of proper cleaning cannot be gained by listening to the chatter of supply salesmen. Different surfaces require different treatment, and simple applications produce astonishing results, with a corresponding saving in overhead, materials, and inconvenience.

Floors are always the most conspicuous thing in every building, and are generally subject to the most abuse. As a result they receive the largest share of cleaning labor. As a rule the finer the floor, the more easily it is ruined by careless cleaning. This rule applies particularly to tile and linoleum, two of the most popular floorings. Linoleum is a combination of ground cork and linseed oil, thoroughly mixed and spread upon a burlap base. This flooring is subject to rotting, cracking, warping and dents, but properly laid and cared for, the better grades of linoleum will outlast almost any other type of flooring material.

Water is the arch enemy of this fine flooring, no matter how carefully used it will eventually find its way beneath the surface, rotting the base and causing warps and odors.

Polishing with good floor wax not only gives the floor a hard brilliant finish, but if properly applied becomes a cushion of protection for the surface. Polishing labor is reduced to a minimum by the use of an electric floor polishing machine. In this way one man can wax and polish over 16,000 square feet of flooring in a day, and not only that, but such a machine revolving at a high rate of speed melts the wax, forces a certain amount into the pores of the linoleum, leaving the surface so hard that it cannot be readily marked by the heel.

The brushes in these machines will stand about six

months of daily use, and two brushes should be kept on hand to allow for cleaning. Gasoline is used to clean the brushes and several days are needed in which to dry them thoroughly before they can safely be used again.

Good wax is made from a caruba base. It dries quickly to a hard finish and covers more space than the same amount of a cheaper wax. In applying wax it is always best to give it a few minutes to dry before polishing. If the room is a large one or a corridor, wax the whole surface first, then begin polishing where waxing was started. This gives a better result, and does not clog up the brush so readily.

It is sometimes necessary to use water on linoleum, where it has been badly neglected and it is desired to clean it before waxing. When this is done, use a bucket and cloth, not a mop. Use as little water as possible, take a small space at a time and dry it immediately. Benzine, alcohol and oxalic acid are the solvents used to remove unsightly spots. After using any of them the spot must be sponged carefully and left dry. Never use brushes on linoleum, as this application is unnecessary and ruins the flooring.

Linoleum, being soft, is readily dented. To prevent this all furniture must either be shod with felt, or hardwood blocks placed beneath the legs to prevent contact with the floor.

#### Tile Floor Easy to Clean

Tile is an opposite type of flooring; it is hard, being made from clay, feldspar and flint. It comes in both glazed and dull surfaces, and in many colors; the coloring matter used is mixed with and becomes a part of the tile so that it will not discolor under ordinary conditions.

Tile is easy to keep clean and white with a minimum of attention if it is cleaned daily with warm water, soap and a mild detergent. Strong solutions of lye or soda will eventually turn the tile yellow, a condition which it is difficult to remedy. Harsh abrasives will so roughen the surface that every bit of foreign matter will adhere to it. These conditions can easily be avoided by using the proper materials in the right way. Scrubbing with a brush should only be resorted to when the tile has been badly abused; as a rule mopping does the work quickly and easily. Hydrochloric acid is the solvent to use on tile to remove rust spots around radiators, etc. The application of this solvent should be followed by a generous flushing with clear cold water, otherwise a burn will result which cannot be removed.

\*This is the third of a series of articles on the general service department of the hospital, prepared for THE MODERN HOSPITAL.

In this class of flooring comes marble which is a limestone, very much softer, and as a consequence more readily discolored. Light plays an important part in this mineral, marble placed in dark rooms is affected in much the same way as white paint—it will eventually turn yellow. It is also easily affected by acids and atmospheric conditions. Marble is readily cleaned with neutral soap and warm water; it may be polished with clear soft water and chamois skin, in the same manner as glass.

Composition floors are generally composed of several different types of floor finishing minerals cemented in concrete; this type of floor is cleaned in the same manner as tile.

Rubber flooring is coming into general use throughout the country. It lends itself admirably to use in hospitals where silence and long wearing qualities are among the most desirable features. This class of floor probably costs less to maintain than any other kind as neutral soap and warm water will keep it in excellent condition.

Concrete and cement floors may be scrubbed or mopped as necessary. Lye is the best medium to use; it must be wiped over with a mop in clear water after use, otherwise it is apt to streak. Sal soda is also largely used for this purpose and is effective, although less so than lye.

Hardwood floors should be handled in much the same manner as linoleum. If the floor is kept polished and furniture well shod no trouble will be experienced from hardwood. Oils and greases should not be applied to any kind of hardwood otherwise it will not be possible to polish it properly. Oxalic acid is the best solvent for black discolorations; lye will remove the entire surface if permitted to remain on the floor too long and will turn the wood black.

Softwood floors may be oiled, painted, scrubbed or polished, as circumstances permit. New floors that are to be oiled must first be perfectly clean. A small amount of stain may be added to the first application to get the desired shade. Four hours after the floor has been treated it should be gone over with a cloth or burlap tied to a push broom, as by this time the floor has absorbed all the oil it will take up and the surplus left on the surface must be removed. Soft floors that are to be painted should be clean and smooth before painting; cement paint is the best to use. Soft wood will polish nicely if it is clean and smooth and the surface treated to two coats of waterproof varnish or shellac before polishing.

#### Patients See the Ceiling

Walls and ceilings are frequently neglected because the management fails to provide sufficient labor to keep them as they should be kept. This situation is unfortunate because the eye of the patient is forever on the ceiling and every tiny spot becomes a mountain as the days go by.

Labor provision for the weekly wall and ceiling wiping should be given consideration. It will pay in reduced mechanical maintenance and is so easily accomplished that it is a shame to neglect it.

Some parts of the walls around basins, etc., need daily washing, and most of the hard paintwork will require daily cleaning and polishing. No matter how good the quality of paint used it will not stand the continued use of sandsoaps, cleansing powders, etc., many of which contain powdered pumice, soda, lye and even harsher ingredients which if constantly used destroy the hardest known surfaces.

Where the hospital paintwork is subjected only to the ordinary wear of traffic and use it requires but an occasional wiping and polishing with a good grade of furni-

ture polish. Three prepared cloths are all the cleaner need carry from one end of the corridor to the other—no bucket to slop around, no drip in the halls, no streaked paintwork when he is finished.

If the scratches, smears, streaks and wear on the finely finished enamels of the hospital were as carefully noted by the executive as the finish of his automobile there would be a lot of careless cleaners out of a job tomorrow.

Soap must be used on occasion. It should be a mild soap, perfectly neutral, or a soft soap made from pure chips (never from soap powder). Under no circumstances should any patented soap compound be used on fine enamel, in fact it should not be needed in any part of the hospital. Soap preparations which clean the surface like magic are plentiful; they are all combinations containing an excess of alkali which will remove the paint or turn it yellow, perhaps both. When they are needed they should be made up on the premises and in this way it is possible to know beforehand what to expect from the product; incidentally you get a strong soap at a soap price, not an unknown preparation at an exorbitant figure.

Soft water is in itself an effective cleaner for fingerprints and light marks on white enamel, without any other medium whatever. Water may be softened by the addition of a small amount of ammonia to a bucket of hard water.

White paints turn yellow from the absence of light, from continuous heat and from the use of wrong cleaning solutions. This condition cannot be remedied except by repainting. Zinc paints are less subject to this condition than those made from white lead.

#### Protect Walls from Wheel Equipment

A wide strip of moulding around the baseboard of corridors and rooms will stop the progress of wheel vehicles in time to prevent their contact with the paintwork and plaster, and thus prevent considerable cleaning and repair work. As a second precaution all wheel equipment should be provided with bumpers of rubber, such as rubber tubing or where necessary heavy water hose. These two precautions cost little and do not detract from the beauty of the building or the usefulness of the wheel equipment.

Sometimes the walls near certain types of patients are subjected to discharge from the mouth. In such instances it is well to hang a sheet across the area thus exposed as the discharge frequently discolors the paintwork and the stain cannot be removed without repainting.

Glass is one of the simplest and most quickly cleaned surfaces with which the cleaner comes in contact if he knows how to handle it properly. The use of soaps, powders, oils and special preparations is not only unnecessary, but does not give even fair results.

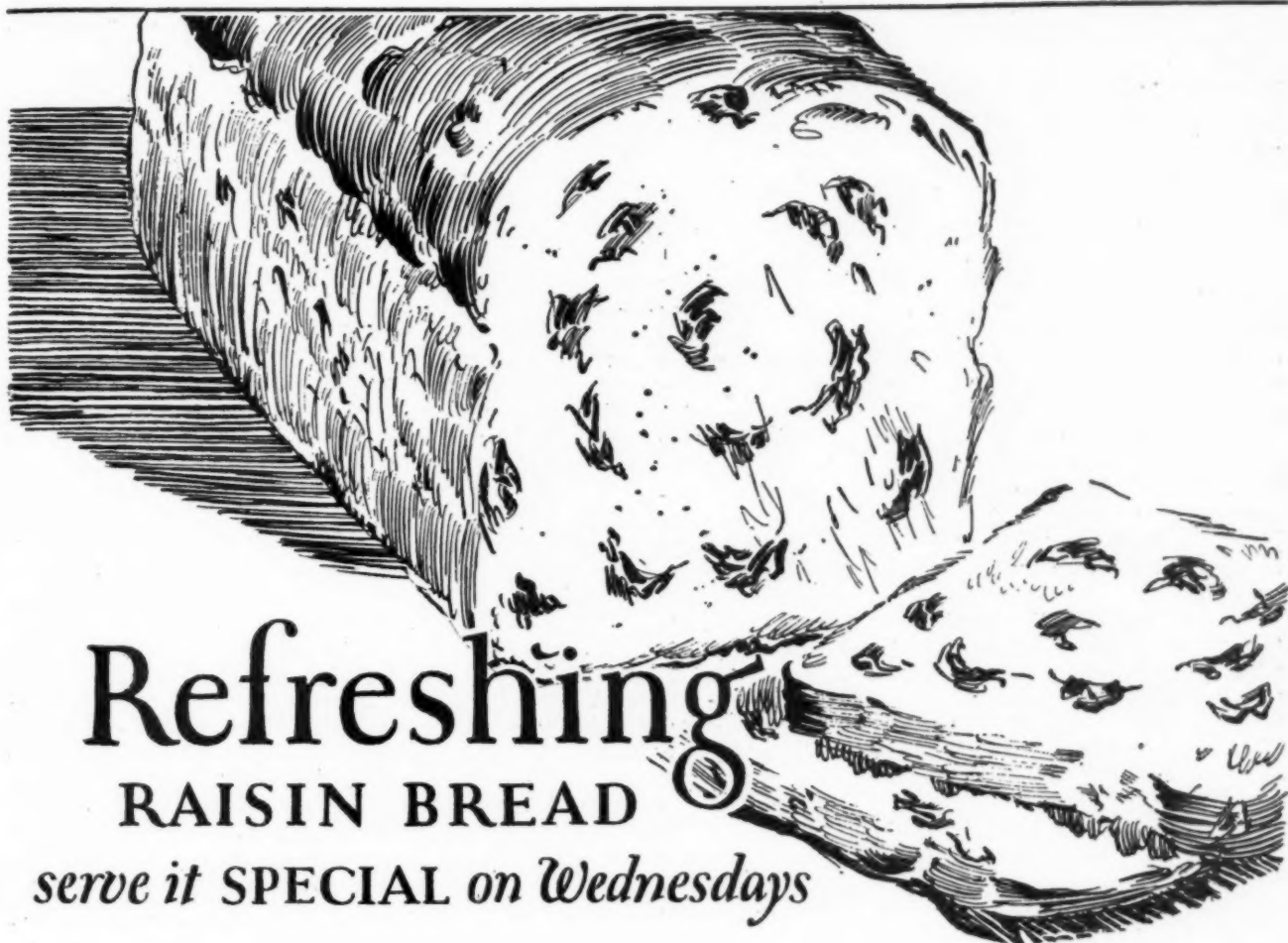
There is one quick and effective way to clean glass and that is by the use of water and ammonia. Add about a tablespoonful of ammonia to the half bucket of water, apply with a cloth, wipe with window chamois, and polish with a clean, dry cloth—this answers the window problem. On very tall windows where a squeegee is necessary, first use the long window brush, follow with the squeegee, then throw the chamois over the rubber and finish. This treatment results in a clear polished finish with a minimum expenditure of material and effort.

Porcelain fixtures may be cleaned with detergent or cleansing powder. Kerosene oil is also effective, although its use is not recommended because it lends itself easily to waste, is disagreeable in odor and adds another item to the variety of stock materials.

Whiting is the principal constituent of all metal pol-



# ADDS ZEST TO SUMMER MEALS



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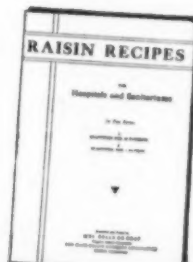
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ishes. It is one of the best and safest mediums for cleaning metal surfaces, particularly nickle, or any plated surface where any considerable wear will remove the finish. When this is used it may be moistened with ammonia and water in a combination of about ninety per cent water to ten per cent ammonia. This same preparation may be used on brass and copper although the commercial polishes are generally effective and do not injure a solid material appreciably.

### Hard Work Best Furniture Polish

Furniture polishing is an art that requires little material and lots of hard work. Practically all commercial cabinet finishers use oil for this work, and if carefully used satisfactory results will be obtained. The article to be polished is first cleaned free of dust. A first grade clear paraffin furniture oil is then placed on a dampened cloth and the cloth rubbed briskly between the hands. This is then applied to the surface to be polished, beginning in the center and working outward with a circular motion; the circular motion is always used where possible. The action is continued until the oil has removed all surface deposits; the article is then dried with cheese cloth in the same manner as the polish was applied. The polishing must continue until the object cannot be finger-marked.

In some parts of the hospital plain unfinished table tops may be used. These tops require constant scrubbing with scouring powder and soap; lye or soda will not get them any cleaner, in fact it will help to darken them and make them look dirty. Oxalic acid is a bleach for unfinished wood; javelle water, made from chloride of lime, is also an excellent bleach for soft woods.

Steam tables in the distributing diet kitchens are prone to accumulate a certain amount of scale. This scale is the result of deposits of salts from hard water; as the water in the steam table evaporates it leaves this deposit behind. Grease also accumulates in the steam tables. The grease may be removed by using a strong solution of hot soda. This helps also to soften the scale which must then be scraped out. This work must be undertaken periodically otherwise the scale finds its way into the plumbing systems and results in stopped up pipe lines.

Where gas stoves and plates are provided they must be kept free of rust. This condition is due to the condensation of moisture around the burners and oven and unless prevented by frequent cleaning and painting (with paint provided for the purpose) it will necessitate a new gas stove.

A day should be provided when all ceiling lights are gone over, domes removed and washed and burnt lamps replaced with new ones. The man who does this work should also wipe ceiling ventilators to keep them in good shape.

### Workman Known by His Tools

Every cleaner should have a knowledge of the materials and tools needed to meet every condition. He should know that better work can be done with clean tools, and understand why it is necessary to keep them in condition.

He should understand that stocks of supplies that are seldom or never used, represent just so much inactive money, and that he must therefore limit his needs to the smallest possible number of articles, conserving at once both money and space. He should take advantage of price fluctuations and get the benefit of fresh supplies.

A six dollar, Russian hair, floor broom may be ruined

by using it on an oil surface, where a dollar horsehair broom would answer the purpose very much better, as it is adapted to rough uneven surfaces, while the hair broom is intended for long smooth sweeps over linoleum, hardwood and floors of like character. Hair brooms are set in cement which becomes soft when brought into contact with oil, the hair drops out and the broom is ruined. The cheaper brooms are wired so that the setting is not affected by liquids.

Floor mops should be made of the best quality cotton strand, which may be ordered twisted or straight as desired. A dirty mop is far worse than no mop at all. There is no single article of equipment in use within the hospital that carries bacteria so readily and thoroughly as the mop. A mop that is properly used and cared for should remain just as white during the time it is in use as it was when purchased, but keeping the mop white is not all the attention it needs. A mop may appear perfectly clean and yet have a most disagreeable odor, and this must be overcome by sunshine and air; one is always obtainable, both should be used when possible.

The life of the mop may be increased by attaching a small piece of canvas to the frame of the mop handle where contact is made, and where most of the wear is evidenced. Mops are not made to scrub with, but it is sometimes necessary to rub down hard on an obstinate spot while mopping. This canvas will prevent the mop from wearing at the point where friction would soon destroy it.

A good quality sheep's wool sponge is a handy piece of equipment to use on a particularly difficult wall where it may be necessary to use neutral soft soap directly on the surface. This sponge saves possible drip and makes it possible to apply a maximum amount of soap to the surface without running up and down the ladder.

### What Equipment to Use

Of the many different types of vacuum cleaners on the market the bag type of portable cleaner is most popular with a majority of those who make industrial cleaning a business. The bag type is light, easy to handle, can be started and stopped where the work is done, has no long hose to knock over articles along the way, does not get in the way of the trucks and Gurneys, and is easy to keep clean. It does the work just as quickly and effectively as the drum type and the stationary type; furthermore, if one gets out of order another is always available. The vacuum cleaner like the mop should always be cleaned before it is put away.

For floor dusting the chemical mop is better than the oil mop. It does not soil so easily, has no hinges to break, does not leave oil streaks, and costs less than the latter type.

The better scrubbing brushes are those made of first grade palmetto or tampico bristles. Of the last named there are many cheap varieties on the market that are worthless. Scrubbing brushes, like all other cleaning supplies, should be bought carefully and a fair price paid in order to get the best results.

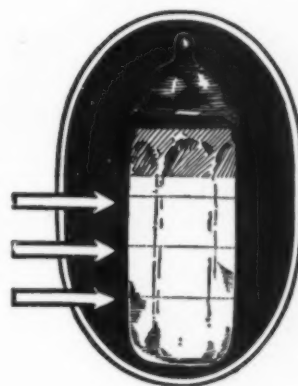
Cleaning men should know that the front of the house begins at the center of the street, and that it is to their advantage to keep the front street and sidewalks as free from dust and oil as possible. It is surprising how much cleaner the lobby and halls will look if the approach is kept free from dirt and dust. A weekly hosing will help considerably to keep this important station looking fresh and attractive.

Where the building foundation and sidewalk meet there



How much of the milk  
did the baby digest?

How much of the milk  
nourishment does the  
baby assimilate?



Two of the vital questions the Pediatricist is constantly called upon to answer. The retarding of complete digestion and assimilation is due almost entirely to the stomach curdling of the milk.

It has been conclusively proved that the protective colloidal action of pure, unflavored Gelatine added to the milk will prevent excessive stomach curdling of the milk which is the most prolific cause of regurgitation, colic, bowel disorders, and malnutrition.

In the research of the specific uses of gelatine in the dietary, conducted by Thomas B. Downey, Ph. D., Fellow at Mellon Institute, University of Pittsburgh, it was conclusively proved by feeding tests that 1% of plain gelatine dissolved and added to milk will increase by 23% the nourishment obtainable from that milk.

The following formula has proved the most efficacious:

Soak for ten minutes one level tablespoonful of Knox Sparkling Gelatine in  $\frac{1}{2}$  cup of cold milk taken from the baby's formula; cover while soaking; then place the cup in boiling water, stirring until gelatine is fully dissolved; add this dissolved gelatine to the quart of cold milk or regular formula.

It is, of course, important to use only the purest form of gelatine, of which the highest grade is Knox Sparkling Gelatine.

NOTE: Copies of this formula will be furnished, without charge, to physicians for use in practice, in any reasonable quantity.

The physician's attention is especially called to the importance of prescribing a pure gelatine, free from harmful acidity, artificial flavoring, and coloring. The highest standard of gelatine purity is always represented by

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is usually to be found an accumulation of filth which destroys the beauty of the front of the house. This can be kept down by occasional washing with hot water and soda; a good time to do this is just before washing off the sidewalk.

The lobby is the gateway to the hospital and its care should be in the hands of an experienced cleaner who knows how to keep the floors, walls and lights in good condition. The counters and woodwork require daily polishing, plants must be given attention by the same person every day, drapes and curtains must be removed and washed or renovated as the case may be, brass work kept up in good shape, and rugs cleaned and turned as necessary.

The man who cares for the lobby is usually a good one to have in charge of the public reception rooms and lavatories. These places need attention several times every day in order to keep them just right and to keep all containers full. It is a good plan to supply sanitary napkins in coin receptacles in the women's lavatories; when this is done fewer towels will be missing, and at the same time a convenience supplied that will be appreciated.

Chloride of zinc in solution of one pint to four gallons is a good deodorizer for lavatories; hydrochloric acid re-

moves uric acid scale. There are several good preparations on the market that come in liquid form which may be used effectively for the removal of this and other discolorations that may accumulate in the bowls and urinals of the lavatories. These are intended to be used only on a porcelain surface, not on enameled surfaces. Their action affects the scale on both sides of the trap. It is necessary to remove this scale because it looks unclean, has a disagreeable odor, and may in time cause a stoppage in the pipe line or trap.

After using any preparation or acid for the removal of scale or color in the plumbing system, the bowl should be flushed out generously so that no acid remains in the joints of the pipe to eat away the oakum and lead with which they are usually joined.

Nickeled plumbing fittings and fixtures in the lavatory are always subject to corrosion. In order to avoid this these fixtures should be cleaned with a smooth polish or whiting about every two weeks. The less polishing they require to keep them clean, the better, as the nickle wears easily and is difficult to replace; too frequent polishing removes the nickle and leaves a brassy surface which looks just as bad as the corrosion.

## THE CARE OF RUBBER GOODS

GENERAL LABORATORIES, UNITED STATES RUBBER COMPANY, NEW YORK, N. Y.

**I**T IS not the purpose of this paper to enter in detail into the various methods of manufacture employed in the production of rubber articles used in hospitals, but rather to indicate in a simple manner types of deterioration which may be encountered and to suggest means for minimizing this deterioration.

Where extreme care must be taken to avoid infection, as is the case in hospitals, it is obvious that rubber goods must contain no ingredient which is toxic, or which will develop toxicity. There must be no material in the rubber compound which will set up any irritation of the skin; especially is this so in the case of surgical goods, such as gloves or tubes.

While these statements may appear rather drastic and disconcerting, it must be pointed out that cases of poisoning or infection caused by rubber articles are extremely rare, if they occur at all. As a matter of fact, it is believed that all rubber goods sold to hospitals are above suspicion.

In addition to the usual service required of rubber goods, hospitals demand that the article shall withstand sterilization. Failure of rubber goods under sterilization will be discussed below. Since the ordinary usage of rubber goods inside and outside hospitals is practically the same, such things as scrubbing and ordinary care need not be considered here.

### Why Rubber Deteriorates

It is, of course, inevitable that rubber goods deteriorate, both from actual use and merely from the effects of time. However, it is equally true that the age which rubber goods may attain depends to a great extent on two factors—the original materials and the care and conditions of use. While this article is intended to discuss mainly the proper care of rubber goods while in storage or in use, it may not be amiss to preface this discussion by a few remarks on the general circumstances

which determine their probable length of service.

In general the effects of time and service on rubber goods may be classified as those resulting from (1) oxidation, (2) after-vulcanization and (3) other conditions brought about by the use to which the article is put. Since the conditions referred to in the third point are more or less inevitable they need no further discussion.

It has long been recognized that there is a wide difference in the ability of rubber articles to withstand these effects, but developments made in the last few years have been most important in improving the quality of rubber goods. With the discovery of new methods of vulcanizing rubber, and in particular the use of special agents, known as accelerators, which permit of a much greater elasticity in the processes, it is possible to produce surgical goods which have much better resistance both to oxidation and over-vulcanization effects than has heretofore been the case. For example, surgeons' gloves have been vulcanized in the past by means of sulphur chloride. Recently we have succeeded in replacing this method of curing which gave a product that deteriorated very easily either in storage or in use, by one which is entirely different and which produces gloves having much better aging qualities than those treated by the sulphur chloride process.

Other products have been improved similarly by the introduction of methods which permit of the vulcanization of rubber goods without any appreciable excess of uncombined sulphur which, of course, is necessary to produce the phenomenon known as after-vulcanization.

### How to Retard Deterioration

Self-aging will progress, regardless of precautions, but the rate of deterioration can be retarded to such an extent that it is scarcely noticeable. Goods should be stored in a cool place, preferably at 70° F. Containers should be intact, and fairly airproof. Metal containers are desir-





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Superintendent

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able. Sunlight should not be permitted to reach the articles. The storage rooms should not contain exposed steam pipes, or, if this cannot be avoided, the goods should be kept far away from the pipes so that the temperature near them does not become high. Goods stored under water will be preserved much better than in air. Carbon dioxide and nitrogen are well-known retarders of deterioration. Numerous surface treatments have been recommended and no doubt are meritorious. They are, however, not necessary if the above broad precautions are taken.

The deterioration of rubber goods by after-vulcanization cannot be avoided when goods are subjected to sterilization. It is recommended, however, that the sterilization be carried out at the minimum possible temperature and in the shortest possible time compatible with efficient sterilization. Dry heat sterilization will cause a much more rapid deterioration than steam treatment. Hard rubber goods are but little affected by steam treatments.

Oxidation will take place at a more or less rapid rate when the articles are subjected to heat. For example, a hot water bag will suffer oxidation on the surface while it is in use, but the oxidation rate will be retarded if the padding or covering is of fairly air-tight material.

There are no specific precautions for the care of tubing in storage, beyond those already pointed out. Where rubber tubing is used to convey liquids (or gases) other than water, the tubing should be thoroughly rinsed out with clean water and hung to drain. Heating as a method of quick drying is not good practice.

Sheeting may be washed with soap and water or with diluted phenol solutions if desired. It should be dried below 100° F. Disinfecting solutions will not damage the sheeting, provided they do not contain acidic ingredients, and are not too concentrated. Naturally, sheeting with but one rubber surface will be more affected than the all-rubber type. A very small amount of free acid is sufficient to destroy the fabric if it is permitted to remain in the interstices of the cloth backing. Oxidizing agents should not be used as disinfectants.

Articles of hard rubber will stand more harsh treatment than soft rubber goods. Repeated heat sterilizations will do little more than dull the polish. Chemical sterilization will have but little effect upon the hard rubber, since the latter is well-nigh insoluble to the majority of chemicals. Permanganates and chromates, if not carefully washed off, may cause tackiness to develop, both in hard rubber and in soft rubber articles. Hard rubber articles are softened somewhat when subjected to the heat of sterilization but resume their original hardness when cool.

#### No Boiling Water in Rubber Bottles

Surgeons gloves and soft rubber instruments should be sterilized sufficiently, but not allowed to remain in the steam any longer than is necessary. The same applies to all thin rubber goods of the semi-transparent type. While in storage gloves should have a plentiful dusting of talc, inside and outside. They should be kept in a relatively cool place, and away from unlimited quantities of fresh air. Thin rubber articles are much more susceptible to oxidation than heavy goods. Cold cured or vapor cured goods (sulphur chloride) resist storage better if a spoonful of ammonium bicarbonate is put in the package containing them.

Boiling water should not be poured into hot water bottles. The temperature should be a few degrees above

that at which the bag is to be used. It is not good practice to pour in hot water and then dilute it to the proper temperature.

In conclusion, the life of rubber goods can be prolonged by storing them in closed containers away from direct sunlight or heat in excess of 90° Fahrenheit. Contact with oxidizing agents should be avoided. Rubber articles should not be heated in open air, nor should they be sterilized for excessively long periods. Disinfection may be carried out with any of the well-known solutions, provided these are not acidic in character or highly concentrated. Goods kept in a reducing atmosphere will deteriorate very slowly.

#### COST OF LAUNDERING FLAT WORK

In discussing the cost of production in the hospital laundry we must bear in mind the fact that there is no such thing as a standard that applies everywhere. Laundries conducted in an equally efficient manner may show great variation of costs, and some may produce work at much lower figures than others. The expenses of various plants must differ, because of differing wage scales, difference in cost of supplies, difference in volume, difference in cost of fuel, and so on. Even the hardness of the water used has an effect on the cost of production.

Wages of laundry workers are, as a rule, higher in large cities than in small. In the south negroes work for a smaller wage than is paid in the north to white workers. Conversely, the production is less per dollar paid the worker in the south than it is in the north, because the worker who can be had at a low wage is low in efficiency. Thus, we see, a low wage scale does not necessarily mean low laundry costs.

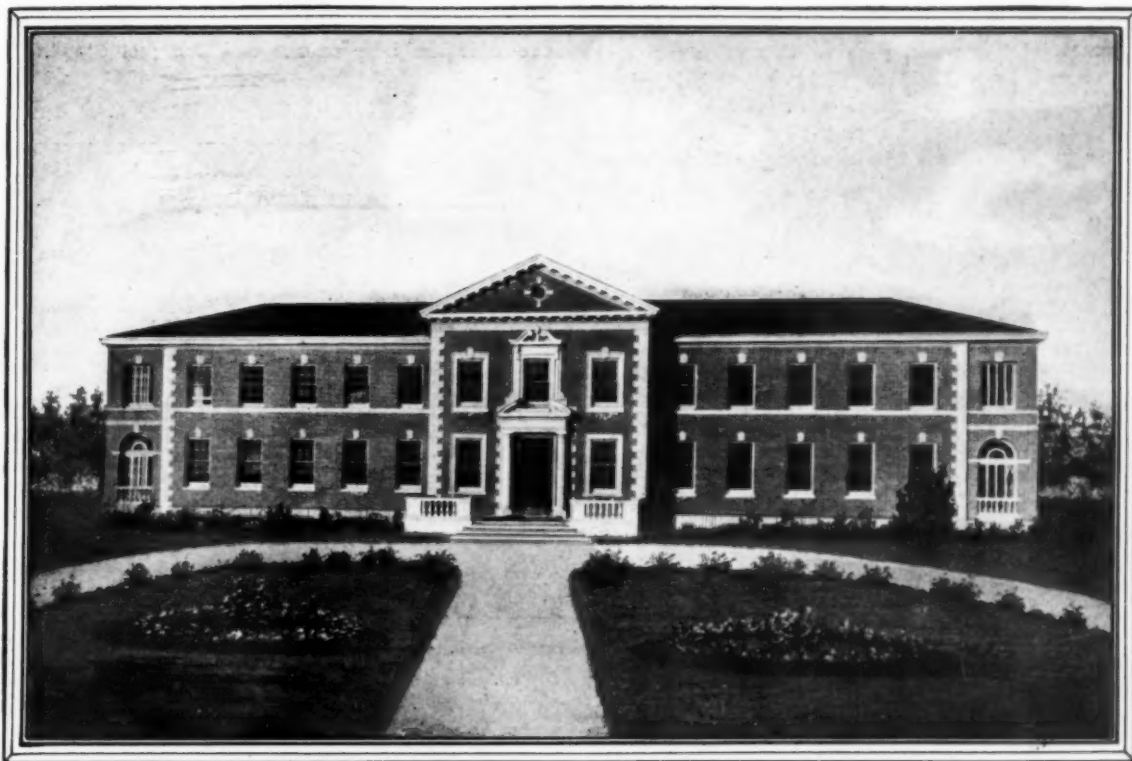
#### Why Costs Vary

Because of higher freight rates, necessitated by long hauls, laundry supplies cost more in some sections than in others. In most cases, but not in all, it is found possible to have lower costs with large volume than with small. Fuel is an important item of expense, and in some places it costs much more than in others. If the water supply is hard, this increases the expense to some degree, because there must be either the cost of maintaining a water softener, or an excess cost for soap because of the hard water.

Each laundry is a separate problem, and each hospital superintendent must determine his costs for himself; but in doing this it may be a guide and help to know what others are doing. As in no group of hospital laundries have cost figures been compiled on a uniform basis, we must for the time being look to the commercial laundry field for data to use in making comparisons. If these figures do nothing else, they reveal the necessity of uniform and scientific cost accounting methods.

Some interesting statistics as to the cost of production of flat work for hotels were recently given out by B. T. Cooke, cost accountant for the Laundryowners' National Association, in an address at a trade gathering. As hotels are not keeping their costs by a uniform method, it was necessary to go by the figures of a group of commercial laundries. There being practically no difference between laundering flat work for a hotel and laundering it for a hospital, we may study these figures with advantage. We must remember, however, that they may be either too high or too low for any specific plant,





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because of varying circumstances that have been pointed out.

### Complete Cost Records Necessary

In a group of plants it was found that the cost of producing commercial flat work, such as that of hotels and hospitals, ranged from \$2.69 to \$8.23 per one hundred pounds. The greater the number of pieces per one hundred pounds, it was found, the greater will be the cost of doing the work. Because of the variation in the number of pieces per hundred pounds, there was the following variation in three different jobs, all done in the same laundry: A, \$3.70 per one hundred pounds; B, \$3.93 per one hundred pounds; C, \$3.25 per one hundred pounds; average \$3.63 per one hundred pounds.

Taking a laundry in which the average cost of production for commercial flat work is \$3.50 per hundred pounds the various items of cost were found to be as follows:

Labor—washing and extracting, 35 cents; ironing, 65 cents; counting, weighing, etc., 14 cents; total \$1.14.

Supplies—washing and extracting, 29 cents; ironing, 5 cents; counting, etc., 10 cents; total 44 cents.

Overhead—washing and extracting, 42 cents; ironing, 44 cents; counting, etc., 2 cents; total 88 cents.

General and administration, 35 cents.

Collection and delivery, 69 cents.

This gives a total cost of \$3.50 per hundred pounds. As a hospital has little or no collection and delivery expense, it would seem fair to deduct that item, or at least most of it, and thus the cost would be \$3 per hundred pounds, or perhaps a little less. True, there are not many hospitals in which the goods are weighed and counted, but there can be no accurate cost records kept unless this is done.

The total cost of the labor and supplies is \$1.58 per hundred pounds, and the overhead cost is 88 cents, or more than equal to fifty per cent of this, bringing the inside laundering cost up to \$2.46. Then there is a general and administration expense of 35 cents, which brings the actual cost of production up to \$2.89, if we omit the item of collection and delivery entirely. If this does nothing else it clearly shows that the figures will be very far from right if one has forgotten to include his overhead and general expense.

### Other Factors Influencing Cost

As has been stated, it costs more to launder one hundred pounds of small pieces than it costs to launder one hundred pounds of larger pieces. This is principally because of the ironing expense, but there are other factors, counting being one. The costs of various items, by the pound and by the piece, will give a fair idea as to the manner in which costs vary with the size of the article. The thickness of the goods is also a factor, as will be seen by comparing the costs of a sheet and a spread, both of which are of approximately the same dimensions. In a laundry where the average cost of producing commercial flat work was 3½ cents per pound, the average costs per piece and per pound were as follows:

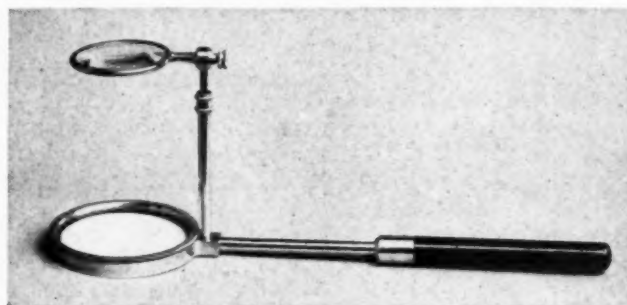
	per lb.	each		per lb.	each
Spreads .....	3 c	9½c	Bath towels .....	4½c	2½c
Sheets .....	3½c	4½c	Dresser scarfs .....	4½c	1½c
Slips .....	4½c	4½c	Tablecloths .....	4 c	4½c
Hand towels .....	5 c	1 c	Napkins .....	6 c	¾c

Napkins, it will be noted, cost twice as much to launder per pound as spreads, and almost twice as much as sheets. These are cost prices, not selling prices, be it remembered. The costs are those of one laundry. Your

laundry may be able to do better than this, or it may not be able to do as well, depending on circumstances. But there are not many laundries that cannot eliminate some waste of time and material and thus reduce expenses. At any rate, without exact data as a guide, one cannot be sure that the best results are being obtained.

### FOREIGN BODY FLUOROSCOPE

A foreign body fluoroscope by means of which an area exposed to x-rays can be outlined or the presence of x-rays can be made known has been developed from a suggestion of Dr. Robert A. Arens, Michael Reese Hospital, Chicago, Ill., who felt the need of such an instrument when removing a foreign body with aid of x-ray.



The screen is three and one-half inches in diameter and is mounted in a unit with a lead glass. The apparatus is circular so that instruments may be used around and under it conveniently. The screen unit can be easily removed when sterilizing the metal parts.

A magnifying glass is mounted above the screen on an adjustable post, so that the fluoroscope may be used without the lens if desired. The instrument is so constructed that it may be taken apart for sterilization and when not in use may be kept in a small case.

### BLUE LIGHTS TO LOCATE NURSES

By LOUIS C. LEVY, Superintendent, Jewish Hospital, Cincinnati, Ohio.

It is suggested that all future installation of signal systems in hospitals should provide lights outside each room to designate the location of the floor nurse.

I have in mind that a small blue light placed alongside the red light over each door should be lighted by the nurse as she enters the room. This could be a simple operation if the push button were located inside the door, and a special key provided for turning the switch.

How often it occurs in a busy hospital that the staff physician goes to the chart room and finds it vacant, as the nurse is engaged in private rooms. The ringing of a hand bell is disturbing; besides it may not be heard. The doctor wants a nurse, but he is delayed and there is a falling down in the service.

My solution would seem to be a fairly good one. A blue light shows the location of the nurse. This is a suggestion that might profitably be considered by manufacturers of the signal system.

The excessive use of cleaning materials sets up a vicious circle: first comes the painter who brightens up everything with paint, enamel and varnish, which cost a lot of money; then comes the maid or porter with mop or brush and strong solutions and takes the paint, enamel and varnish all off again. And so it goes—the hospital all the while footing the bill.—*The Bulletin of the California Lutheran Hospital.*





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Diagnosis	No. of Cases	Cured		Im- proved		No Change	
		No.	%	No.	%	No.	%
Coryza.....	388	288	74.2	91	23.5	9	2.3
Acute laryn- gitis and pharyngitis	127	99	78.0	24	19.0	4	3.1
Acute bronchitis..	241	192	80.0	47	19.5	2	0.5
Chronic rhinitis....	106	33	31.1	41	38.6	32	30.2
Chronic bronchitis..	47	34	72.3	12	25.5	1	2.1
Chronic laryngitis..	2	2	100.0				
Whooping cough.....	9	8	88.8	1	11.1		
Influenza....	11	9	81.8	2	18.1		
	931	665	71.4	218	23.4	48	5.1

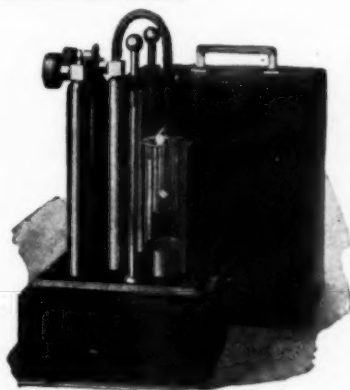
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## DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York  
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association, 370 Seventh Avenue, New York

### PRINCIPLES AND FORMS FOR OUT-PATIENT RECORDS\*

THE committee on records of the Associated Out-patients Clinics of New York started its deliberations in May, 1923. It was brought into being in order that representatives of the various types of out-patient departments in the city, public and private, general and special, might come together for the purpose of analyzing current practices in the matter of forms and records with a view toward adopting minimum standards.\*

The committee recognized from the start the fact that out-patient departments function under inadequate financial support and that they differ in construction, equipment, and organization. Most of these institutions are attached to hospitals; some are not. In the former group there are those in which the clinical organization for both in and out-patients is the same and those in which the two clinical organizations are different. These are a few of the factors that are intimately connected with the question of forms and records, and a search for the ideal in this field was early seen to present difficulties through lack of uniformity in the ambulatory treatment of the sick poor.

An illustration of local difficulties may be cited in the following instance. The quotation is from a letter from the Shantung Christian University to Mr. Michael M. Davis,

\*Report of committee on records of the section on administration of the associated out-patients clinics of New York. Dr. George O'Hanlon, chairman of this section, appointed a special committee on records consisting of Dr. E. M. Bluestone, Mount Sinai Hospital (chairman), Dr. Charles B. Bacon, City Hospital, Dr. Mark L. Fleming, Bellevue Hospital, Mr. Joseph D. Flick, New York Society for the Relief of Ruptured and Crippled, Dr. Frederick MacCurdy, Presbyterian Hospital, Mr. James U. Norris, Woman's Hospital, and Mr. George F. Sauer, Lenox Hill. Prior to the preparation of the report Dr. Bacon and Mr. Sauer resigned. The material was gathered for the committee and the report prepared by Elizabeth L. Brezee, Associated Out-Patients Clinics. The committee would be glad to receive from readers any criticisms, which may be addressed to Dr. Alec N. Thomson, Associated Out-Patient Clinics, 17 West 43rd Street, New York City, who acted as secretary to the committee.

The committee on records was created as a sub-section of the administrative section of the Associated Out-patients Clinics of New York. Its purpose was to study, from an administrative point of view, record forms used in out-patient departments and to analyze them with a view toward drawing up a set of records which would meet minimum requirements. A study of this type was thought advisable because the various professional groups of the Associated Out-Patients Clinics were asking for definite information with regard to the content and use of records.

The present installment deals with general recommendations of the committee and includes facsimiles of the six forms adopted as providing minimum requirements. In the next installment will appear tabulations of forms studied, giving the content of many now in use; it will also include discussions and conclusions arrived at by the committee in connection with the various items. It will not be possible to record adequately both sides of the argument in the case of the many topics discussed but the more important reasons will be found for recommendations which were adopted.

Jr., executive secretary, Associated Out-patients Clinics.

Our main difficulty has been with the record filing system. As the Chinese language has no alphabet, it is impossible to file our cards according to names but we file according to number with a cross index of names Romanized, in case admission cards are lost. This is not so simple as it seems, as so many of the names, when Romanized, look like each other and also the Chinese change

their given name automatically when they assume an advanced position either in school, age, or business. The women have no given name but use their husband's surname followed by their maiden surname. As there are only a little over one hundred surnames you can realize the difficulty we are up against with many surnames of the same sound. We then depend on age, residence, etc." Such are the troubles in China over and above what must be encountered in this country.

The first decision made by the committee was to the effect that a series of forms and records be adopted as minimum for any first class clinic. The purpose of these forms and records was to

give the elementary requirements for institutions which were coming into being; variations of these forms would necessarily depend on local requirements for out-patient departments already in existence. It was hoped that the effect of these studies would be similar to that felt by the individual members of the committee, who were stimulated to deeper thought by the arguments presented at its meetings.

The forms considered to be indispensable to the satisfactory functioning of any out-patient department were (a) admission card, (b) index card, (c) transfer and refer form, (d) history face sheet and (e) history continuation sheet; in institutions in which the history re-



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mains in the parent clinic and is not transferred with a patient, an additional necessary record is the clinical abstract form. Forms for business and statistical purposes will be taken up later but in the present study only the six listed above are discussed. The method adopted by the committee in its study of existing forms was essentially as follows: the secretary gathered blank forms from all types of out-patient departments and prepared tabulations showing, for each of the forms under consideration, the items which appeared and the order of their frequency. With these tabulations as the starting point for the discussion of the forms, the committee considered each item listed, either retaining it as indispensable or discarding it as unessential. Certain items that were not held to be absolutely minimum seemed to the committee to be advantageous and appear as recommendations. Incidental suggestions concerning the disposition of forms and method of making entries are included from time to time as being relevant to the discussion.

A difficulty encountered early in the discussion was the confusion in the interchangeable use of the terms "dispensary" and "out-patient department"; after consideration of this question the committee concluded that the former was an unsatisfactory term in that it was tied up with the old idea of giving away medicines. "Out-patient department" was adopted as the preferable term and possible of substitution for "dispensary" in the majority of cases, since most such institutions are either part of or closely connected with hospitals or "in-patient departments," as they might be termed in contrast.

A principle which strongly guided the committee was the necessity for cooperation between the clinical and administrative groups. It was decided that items of a clinical nature which were to appear on the forms would not be adopted until the various clinical and laboratory sections were given the opportunity of making suggestions as to minimum and advisable requirements. Thus the history form, with minimum administrative items as determined by the committee, was submitted to

Name.....	No.....
Clinic.....	Date.....
.....	.....
.....	.....
.....	.....
Days and Hours	
NAME OF OUT-PATIENT DEPARTMENT	
Always Bring This Card With You	
This out-patient department is for the treatment of the poor. The law does not permit us to treat those able to pay for the services of a private physician.	

Form A—Admission card (2¼"x4")

Name.....	No.....
Address.....	
.....	
Male      Female	Date.....
Clinic.....	
.....	
This patient claims inability to pay for the services of a private physician.	
NAME OF OUT-PATIENT DEPARTMENT	

Form B—Index card (3"x5")

Transfer	Refer
Date.....	
From.....	
To.....	
To report on.....	
Day and Hour	
NAME OF OUT-PATIENT DEPARTMENT	

Form C—Transfer and refer slip (2¾"x3")  
(Number may be repeated in lower right hand corner if filing method requires)

NAME OF OUT-PATIENT DEPARTMENT	
Name.....	No.....
Address.....	Date.....
(Note change)	
Clinic.....	
.....	
(Note change)	
Male Female S M W D Sep. Des. Age...	
(Encircle item designated)	
Exact Occupation.....	No.....

Form D—History face sheet (8½"x11")

NAME OF OUT-PATIENT DEPARTMENT	
Page.....	No.....
Name.....	

Form E—History continuation sheet (8½"x11")

the various sections with this purpose in view. Clinical forms for out-patient use will be published later as a separate study. The committee felt throughout its deliberations that although it was, strictly speaking, an administrative sub-section, the clinical importance of the record was to be kept constantly in mind. The clinical value of the record to the patient calls for an adequate series of forms; the clinical value of the record to other patients in a series calls for an adequate filing system with each accessible to the administrator and clinician.

### Unit Filing System Preferred

With these ideas in mind a detailed study was made of record filing systems, special attention being given to the central unit system serving both in- and out-patients. By a central filing system is meant one in which the records of all patients are filed in one place easily accessible to all clinical branches of the institution. The unit system referred to is one in which all clinical entries of a patient (i. e. both hospital and out-patient records) are grouped logically in one folder. It was felt that this was the ideal system for keeping records in that the clinical life history of a patient was unified and located centrally, thus showing all clinical entries from the first visit of the patient to the hospital or out-patient department till the date of final discharge, in contrast to the scattered system of keeping records in the individual clinics. In cases where it is impracticable to file in- and out-patient records in the same place, on account of the construction of the building, it was recommended that central unit out-patient department filing be adhered to.





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In connection with the alphabetical index file, the committee studied the relative merits of visible and invisible filing systems; it concluded that the visible system was not adapted to this purpose because of the expense involved and the space required. It recognized, however, the fact that certain features of clinic management of which follow-up was cited as an example, might be facilitated by the use of the visible system.

### Time-Saving Arrangement of Files

An endeavor was made to so arrange forms as to permit of the minimum amount of time in the handling of admissions by the minimum number of employees and to permit the greatest ease in filing and in finding filed material. Thus the general recommendation was made that the patient's name and number should be given space at the top of all filed envelopes, sheets and cards. An exception to this rule was made in the case of the clinical abstract and the history sheets; on these forms the name of the out-patient department was placed at the top since it was felt that institutions were accustomed to this arrangement and that it would not materially interfere with the ease of filing, especially if the printing of the name of the institution was not too large. The number should always be placed near the right hand edge; this means that in looking for filed material the eye does not have to search around for the identifying item but finds it always in the same relative location, no matter what form is under consideration.

History sheets of the dimensions recommended are of such shape and so printed that they lie on their sides in the file drawers; in such cases it is highly advantageous to have the history number appear in the right hand corner of the sheet as filed instead of at the top of the sheet only. This is not necessary for any but the history face sheet and there only when no history envelope is used; when envelopes or folders are used, the printing on them can be parallel to the long axis, thus naturally bringing the history number in the upper right hand corner as filed.

A good quality of paper was recommended for the history and abstract sheets as being preferable to cards, since it allows for typing; and single sheets preferable to double, as being sufficient in a majority of cases. These forms should be of the same size as the hospital sheets. Paper was recommended for the transfer and refer form and cards of standard size for the admission and index forms. Under each form is given the size recommended. In determining size, consideration was given to the dimensions of standard file drawers and of paper and card stock. In ordering forms in sizes of which the stock size is an exact multiple, waste in cutting and hence unnecessary expenditure can be avoided.

The suggestion was made that whenever a choice is to be made between two or more printed items on a form (as between "male" and "female" or between "transfer" and "refer") the item designated should be encircled. This seems to be the most satisfactory method since underlining to indicate the item designated is easily confused with drawing a line through the word to indicate the item not designated; if the negative items are crossed out by means of diagonal lines or x's, this requires several such lines in certain cases, such as the letters on the history sheet used to indicate social status (S M W D Sep Des). Moreover, it seems more logical to indicate the positive than the negative conditions.

The committee recommended the maintenance of a diagnostic file, based on one of the well-known classifica-

#### NAME OF OUT-PATIENT DEPARTMENT

Name.....No.....  
Transfer Refer Date.....  
From.....To.....  
To report on.....  
Day and Hour

#### Clinical Abstract

#### Laboratory Findings

#### Remarks

Signature of physician.....

If this is a refer, use reverse side of sheet for consultation report and return to parent clinic.

Form F—Clinical abstract form (8½"x11")

tions of disease, in order to encourage scientific research. For the purpose of the diagnostic card it was deemed sufficient to note only the disease and history number to which it referred.

The following definitions, recommended by the Associated Out-patients Clinics to the State Board of Charities of the State of New York, were endorsed by the committee on records:

(1) The terms *dispensary* or *clinic* are used to designate a medical institution which cares for ambulatory patients in contrast to a hospital which cares for bed patients. Included in "ambulatory patients" should be all those former hospital patients who return for "follow-up." Such institution may be either the *out-patient department* of a hospital, i.e., part of, or closely connected with, the hospital, or it may be an entirely separate organization—an *unattached dispensary*. In the case of out-patient department accident ward statistics should be included, since the patients are ambulatory.

(2) The term *clinic* also may refer to a particular department or division of the out-patient department or of the unattached dispensary; when thus used it is usually preceded by some modifying term such as *medical clinic* or *gynecological clinic*. This is what is indicated by the heading "Service or Department" in the State Board of Charities annual report form (page 2, section 10).

(3) By *number of individuals (or patients)* during any given period is meant the number of different persons cared for during that time. It may refer either to the clinic as a whole or to one division or department.

(4) The New York State Board of Charities' annual report form asks for *number of individuals treated* in each department during the year. This requires for each department the counting once, and only once, of each person treated in that department during the year; it includes both those persons who are new to the department (those who have never before been to that particu-



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lar department, though they may have received treatment in some other division of the dispensary), and the first visit during the year of those persons who have previously been treated in that department.

(5) The state board does not require the number of individuals treated in the dispensary as a whole. This would be a different figure from the sum of the individuals treated in all the departments, since some persons attend more than one department during the year and would hence be duplicated in such a total.

(6) A *visit* means the admission of an individual to a clinic or department for any treatment or attention therein. If any individual is admitted to two departments on the same day, it should be recorded as two visits. Thus the total number of visits over a given period is equal to the total visits to all the departments over that period.

(7) The *revisits* of any one person to a department during the year are all the visits he makes to that department after his first visit that year. The total number of individuals plus the total number of revisits equal the total number of visits for a department.

(8) The word *case* refers to a particular kind of clinical problem from the medical point of view. A *clinical problem* is one in which the original diagnosis is maintained or in which the treatment is being given for complications or sequellæ of the same diagnosis. The word *case* should not be used as a statistical term for measuring the bulk of attendance but its use should be confined to matters of medical research.

The following recommendations are made:

(1) A central unit filing system is strongly endorsed. Out-patient departments should make every effort to approach this ideal where the record system is not central or unified. A more detailed account of this system as used by the Presbyterian Hospital of New York City will be published by Dr. MacCurdy as part of this study.

(2) It is recommended that a systematic inspection of clinical records be undertaken by the senior members of the staff.

(3) Out-patient departments should maintain a cross-index file for diagnosis at least and, if possible, for complications.

(4) The general principle of cooperation between health agencies of all kinds in the matter of records is strongly emphasized.

(5) Clinical information should not be placed in the hands of patients but transferred by messenger or mechanical carrier.

(6) Records should be typewritten wherever possible. Names, at least, should be printed.

(7) Rubber stamp signatures should not be used.

(8) All entries on records should be dated and signed, or at least initialled by the responsible individual.

(9) The use of a cash register in the out-patient department is strongly advised.

(10) The name of the institution and the date should appear on all printed forms.

(11) Wherever the name of the patient is used his history number should be added.

(12) Where the address of a patient is recorded space should be left for change of address and a reminder added.

## OHIO DIETITIANS HOLD THIRD ANNUAL MEETING AT CEDAR POINT

(Continued from page 162)

all teachings direct or indirect should be so permeated by spirit of open-mindedness that students will have the attitude which permits them to be receptive to the truth

and to be unhampered by prejudices.

June 11, Miss Irene Willson, president, Pennsylvania Dietetic Association, Homeopathic Hospital, Pittsburgh, Pa., read a paper on "Old and New Theories of Diet."

Miss Geraghty spoke on the subject of "The Dietetic Instruction of the Student Nurse."

A joint session with the Ohio Hospital Association was held at 2 p. m. Miss Bertha Beecher read a paper on "The Young Dietitian in her First Position." Miss Bess Gatton gave a talk on "The Organization of the Main Kitchen and the Diet Kitchen." Miss E. M. Geraghty read a paper on "The Responsibility of the Dietitian in the Small Hospital."

At 3 p. m. Dr. A. J. Beams, Cleveland, gave an illustrated address on "The Dietetic Instruction of Patients." He said in part:

"The dietary instruction should not stop when the patient leaves the hospital, but should be carried into the home. Of course this is not possible when the patient lives out of town. If the dietitian goes into the home she has a better idea of the social and financial status of the patient and has a much better basis from which to work in preparing a diet suitable to that patient. It is often possible to work out menus for the rest of the family so that no additional expense will be added in procuring certain foods for the patient."

"The patients appreciate the interest that is shown and especially the home calls."

In the evening a dinner was held with the Ohio Hospital Association. Dr. J. C. Doane, superintendent and medical director of Philadelphia General Hospital, Philadelphia, Pa., represented the dietetic association. His topic was "The Doctor and the Dietitian."

Thursday morning Miss Uarda Faine, department of public health, Columbus, Ohio, read a paper on "The Place of Dietetics in Public Health Education."

"The public is interested in dietetics, the public needs dietetics. May I suggest that we as dietitians be progressive in our objectives but conservative in our methods. In conclusion may I stress the obligation that the privilege of being recipients of special training places upon all dietitians?"

Miss Bertha Beecher read a paper on "The Education of the Employee."

"It is obvious then," Miss Beecher said, "that the first step in the education of the employee (the basis of which is fairness and intelligence), is:

"To create an atmosphere which will produce self-respect and a feeling among your employees that they are doing an important work and are a vital part of the institution."

She gave as the steps in the creation of this atmosphere (a) 'Evident interest in the individual, (b) an attitude of respect devoid of patronage, (c) an attitude of cooperation, (d) an attitude of self-control.

Other speakers were Miss Marion Peterson, Miss Mayme Lewis, Mrs. Lulu Sidwell Hawkins, and Miss Hazel Lease, who spoke on "Opportunities for Education in My Present Location." Miss Bess Gatton read Miss Katherine Harris's paper on the same subject.

Honorary membership was conferred on Miss Rena S. Eckman, Michael Reese Hospital, Chicago, Ill.; Miss Mary E. Parker, College for Women, Western Reserve University, Cleveland, Ohio; and Miss Irene Willson, Homeopathic Hospital, Pittsburgh, Pa.

The following officers were elected: president, Miss E. M. Geraghty; vice-president, Miss Dorothy Christie; and treasurer, Miss Bertha Beecher.



# Prevention of Acidosis

## —an Important Hospital Function

Since the hospital is primarily a public health agency, its function includes not only the diagnosis and treatment of the immediate disease or injury, but safeguarding against complications and teaching the patient simple fundamentals of health protection.

The service of any hospital group may properly include educational work toward the end of preventing acidosis since it is a forerunner of such serious organic troubles.

This condition resulting from ill balanced metabolism is frequently observed for the first time when the patient enters the hospital for diagnosis and treatment of some other ailment. Whatever may be the underlying cause the simple corrective treatment here discussed should be considered by those responsible for the treatment and care of patients in hospitals and similar institutions.

Gastric hyperacidity, acidity of the mouth and other of the more obvious manifestations of acidosis are promptly counteracted by Phillips' Milk of Magnesia which has a pronounced affinity for acids, the harmless resultant compounds being readily excreted.

The increasing use of sodium bicarbonate by the public to control "acid stomach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

### DOSAGE

The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.) This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.) The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

# PHILLIPS' Milk of Magnesia

**CAUTION.** Beware of imitations of Phillips' Milk of Magnesia. The genuine product bears our registered trade-mark. Kindly prescribe in original 4-ounce (25c bottles) and 12-ounce (50c bottles) obtainable from druggists everywhere.

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When using advertisements see Classified Index, also refer to YEAR BOOK.

## MEETINGS, CONVENTIONS AND CONFERENCES

### TRI-STATE HOSPITAL ASSOCIATION MEETS IN THIRD ANNUAL SESSION

**T**HE Tri-State Hospital Convention, participated in by the hospitals of Minnesota, Iowa and Wisconsin, held its third annual conference in the assembly chamber, state capitol building, Madison, Wis., June 25, 26 and 27.

The opening session, Wednesday morning, was called to order by the Rev. Herman L. Fritschel, president of the Wisconsin Hospital Association. After the invocation by Rev. Otto J. Wilke, Madison, and pending the arrival of the Hon. John J. Blaine, governor of Wisconsin, Dr. James P. Dean, president, Dane County Medical Association, brought the greetings of his association to the convention. He pointed out the extreme importance of hospitals to the successful practice of medicine and cited the recent hospital developments in Madison as typical of what is going on throughout the entire United States.

In his address of welcome, Governor Blaine pointed out that the lack of hospital facilities in various communities results in an enormous amount of unnecessary human misery and said that, inasmuch as the greatest asset of the nation, as of the individual, is good health, it is impossible to exceed the speed limit in providing essential hospital facilities. The hospital in his opinion is as much a part of the community as the school and the church. He pointed out that after the war Wisconsin was the first state to erect a soldiers' memorial hospital for the care of mental cases and outlined other hospital activities in which the state is engaged.

#### Plea for More A. H. A. Members

In his address as president, the Rev. Herman L. Fritschel presented statistics showing the relative hospital facilities in the states of Minnesota, Iowa and Wisconsin, and pointed out that only 119 of the hospitals of these three states are members of the American Hospital Association. This, he felt, indicates the need of active propaganda for more members. He urged a greater attendance at state hospital conventions in the future, pointing out the vast amount of experience relating to hospital affairs that is available at these meetings, and characterizing them as post-graduate courses in hospital administration. If state hospital associations are to be successful Mr. Fritschel feels that they should have definite programs of activity.

Wednesday morning's session closed with an interesting paper on "Central Schools of Nursing" by Miss Gale Fauerbach, R.N., instructor, Central School of Nursing, Milwaukee, Wis. Miss Fauerbach outlined the reasons

leading to the establishment of central schools of nursing, pointing out especially the opportunities for better instruction and better equipment. She briefly outlined what is being done along this line in Detroit, Mich., Utica, N. Y., Grand Rapids, Mich., Kansas City, Mo., Philadelphia, Pa., New Haven, Conn., and Cleveland, Ohio. "The university school of nursing," said Miss Fauerbach, "will produce a much needed body of leaders in the nursing field." Miss Fauerbach pointed out that while in establishing a central school of nursing it might be necessary in the beginning to make an affiliation with high schools, these schools cannot offer professional standards and therefore central schools of nursing should work for something higher.

Wednesday afternoon's session began with a paper by Dr. Bert W. Caldwell, superintendent, University Hospital, Iowa City, Iowa, on "The Relation of the Teaching Hospital to the Community." The teaching hospital, Dr. Caldwell said, differs from the general community hospital in the variety rather than in the extent of its functions. He prophesied that the time was not far distant when every hospital, whether a community hospital or a hospital publicly owned and operated, would be affiliated with a central teaching hospital, thereby giving them the advantages of the extensive centralized facilities. Dr. Caldwell deprecated the construction of large teaching hospitals. The cost of administering teaching hospitals of more than 500 beds was too great. It would be preferable in his opinion to have one central teaching hospital of about 500 beds and supplement this central institution by the construction of small hospitals scattered about the state.

#### Hospital Needs Business Manager

In discussing the subject of hospital accounting Mr. John E. Ransom, representing the American Hospital Association, urged that the business end of hospitals be placed on a sound business basis. "Hospitals," he said, "may be charitable institutions but they are not institutions for the care of incompetent bookkeepers." Hospitals should keep books that would compare favorably with books kept by commercial organizations as hospitals have a greater obligation than business enterprises to conduct their affairs in a businesslike way, for they are spending money intrusted to them for a specific purpose. A hospital should have a good business manager to look after the business affairs of the institution.

The Rev. H. L. Fritschel contended that endowments are



## "I've Really Come to Love My Work Since I've Worn These Shoes," Said One Nurse

SHE was a bright young woman, perfectly trained, sincere and hard working—yet she found nursing irksome, tedious. At night her nerves would be on edge, her skill was being discounted by a physical dread of the exacting duties.

Then she started wearing the Arch Preserver Shoe. She found an immediate change. She could really stand and walk as much as she wished and never have the slightest foot annoyance. She also realized shortly that she was feeling better, more vigorous and ready to take up a case with real enthusiasm for her work. She found that the concealed, built-in arch bridge of this shoe *does* prevent strain; she found that the flat inner sole *does* prevent pinching of the bones, nerves and blood vessels of the foot. She found—and this is most important of all—that she had no physical weakness, but that her trouble was entirely due to *abused* feet.

In addition she found she could have happy, useful feet, and also wear pretty shoes at the same time.

Won't you let us send you our little booklets, No. 210 "How to Keep the Feet Young," and "Why the Arch Preserver Shoe Preserves the Foot."

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Nature plans that the foot rest on heel, ball and outside arch.



Civilization demands that heel and arch be raised.



The Arch Preserver Shoe satisfies both Nature and Civilization.



"KEEPS THE FOOT WELL"

Sold by over 2000 dealers. Look for this Trade-Mark on the sole and lining. Styles for all occasions. All widths, AAAA to E. There are seven patents embodied in Arch Preserver Shoe construction. These are vested solely with The Selby Shoe Company, Portsmouth, Ohio, for the making of women's and misses' shoes, and with E. T. Wright & Company, Inc., Rockland, Massachusetts, for the making of men's and boys' shoes.



## THE ARCH PRESERVER SHOE

*Supports where Support is needed. — Bends where the foot bends*

a special trust and consequently should be especially accounted for, and he illustrated how his institution gave an exact accounting of its endowments. Dr. Walter E. List said that hospital accounting is to the superintendent what the laboratory is to the clinician. Monthly reports tell of departmental activities and these monthly reports may be used to make up the annual report.

An illustrated paper on "Physiotherapy in Gynecological Diseases," by Dr. Henry Schmitz, physiotherapist of Chicago, followed. Dr. Schmitz's paper was discussed by Dr. J. C. Elsom, head of the physiotherapy section of the Jackson Clinic, Madison, Wis. Dr. Elsom predicted that within a few years all hospitals would have physiotherapy departments which would be managed intelligently and scientifically.

The concluding paper of this session was read by Dr. C. A. Harper, state health officer of Wisconsin, Madison. The paper dealt with the relation of the state board of health to the hospitals in the general health program. Dr. Harper called attention to the eight laboratories in the state under the supervision of the board of health where certain types of work are done without charge for physicians in hospitals.

Dr. Harper contended that while general hospitals should not give tuberculosis cases care for an indefinite length of time they should be willing to receive them temporarily for diagnosis and until they can be transferred to tuberculosis sanatoriums. Hospitals that are unwilling to do this are not, in Dr. Harper's opinion, giving the community the best service possible.

Dr. Harper also pointed out that under proper technic venereal diseases are no more infectious than diphtheria or scarlet fever, and that therefore they should not be refused admission as such to the general hospital, for there are times when venereal disease needs bed care, and nurses should know the cases admitted as such as well as they know cases of diphtheria or scarlet fever.

"Hospital superintendents," Dr. Harper said, "should familiarize themselves with the requirements of the state laws regarding reportable diseases."

### Three Types of Hospitals

At Thursday morning's session, Dr. K. H. Van Norman, president of the Minnesota Hospital Association, presided. The session was opened by an illustrated talk on hospitals in relation to medical schools by Dr. Charles R. Bardeen, dean of the medical school, University of Wisconsin, Madison. Dr. Bardeen outlined three types of hospitals as follows: First, hospitals established merely to take care of the sick of the community. Some of these are affiliated loosely with medical schools. Second, hospitals established for the care of the sick and for medical instruction. Third, hospitals built primarily from the standpoint of medical education and only secondarily for the care of the sick.

Teaching hospitals, in Dr. Bardeen's opinion, should be so constructed as always to conduce to the welfare of the patient, in order that medical students may learn the great importance of proper hygienic conditions. It is a mistake to regard the wards of teaching hospitals merely as laboratories. Hospitals connected with medical schools stood in great need of adequate laboratory facilities not only to be used in teaching the students but for purposes of investigation and research. An intimate relation should be established between the hospital laboratory and the various laboratories of the university.

When speaking of the relation of other hospitals to the university hospital Dr. Bardeen expressed the opinion that

university hospitals should not do all the charity work of the community, as this imposes too heavy a burden.

The second paper of this session was read by Dr. W. F. Lorenz, director, Psychiatric Institute, Mendota, and professor of nervous and mental diseases of the University of Wisconsin. This paper dealt with the services of the psychiatric institute to hospitals. Dr. Lorenz stated that the purpose of the psychiatric institute is to investigate cases of mental disease and then promote measures of prevention. He contended that certain clinical laboratory facilities must be centralized because of the expensiveness of the equipment and the time and skill required in making certain difficult tests. Under this scheme there would be enough work to require the full time services of trained pathologists and technicians. The average technician, in Dr. Lorenz's opinion, cannot do much of the serological work and blood chemistry which modern medicine calls for. This work should be centralized in the state laboratory.

Dr. Lorenz pointed out that certain severe and prolonged illnesses have definite mental effects and that any measures that will help to correct physical disease will help to correct mental trouble. He stated that the psychiatric institute had developed a medium in which blood will remain as drawn from the body and can be transported any distance for examination. This should be regarded as an important discovery in view of the fact that blood transfusion as a remedial measure has been revived.

Dr. Lorenz made a plea for the admission of mental diseases into general hospitals. To hospitals that demur he pointed out that they not infrequently have pneumonia cases with extreme delirium which is far more severe than ninety per cent of mental illnesses. We call the police officers or the sheriff in cases of mental illness because we are woefully ignorant of these diseases and their causes.

### Pathologist Should Be on Record Committee

The closing paper of this session was read by Dr. F. P. McNamara, pathologist, Finley Hospital, Dubuque, Iowa. Dr. McNamara pointed out that hospital trustees have a distinct responsibility in connection with the character of the medical service their hospital renders the community. This being the case, how can the average trustee or layman judge of the value of the medical service rendered by the hospital? This value can be determined, in Dr. McNamara's opinion, by the results obtained in the institution and these are to be determined from the hospital's records. Dr. McNamara discussed the question of how reports could be used to determine the efficiency of the medical staff and urged that the pathologist of the hospital be made a member of the hospital's record committee. "The interpretation of tests," said Dr. McNamara, "is very important and the pathologist should be called upon for this service."

Dr. McNamara made a plea for autopsies and expressed it as his belief that frequently autopsies were not made because the physicians and surgeons did not care to have their inefficiency exposed. The success of the laboratory depends on a trained pathologist. Dr. McNamara contended that every 100 bed hospital should be a health center. He pointed out that the pathologist could give public health lectures without being accused of "drumming up trade." He also made a plea for the establishment of pathological museums, pointing out that the specimens thus collected are of scientific interest, can be used in making demonstrations to nurses and interns and can





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## **Heavy Aluminum Ware**

*Never  
needs  
tinning*

*No joints  
or seams  
- easy  
to clean*



Illustration shows a "Wear-Ever" Aluminum Deep Stock Pot with Spigot, Strainer and Cover.

The faucet on this Stock Pot is threaded into a boss which is welded on the pot, doing away with all lock nuts and washers.

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metal*

HEALTHFUL  
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## **BAKING POWDER**

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Derived from Grapes

Contains  
No Alum  
Leaves No Bitter Taste

even be judiciously used in the education of the general public.

Dr. McNamara pointed out that by having 100 bed hospitals in various communities do the laboratory work of the community a full time pathologist can be employed.

Dr. McNamara's paper was discussed by Dr. William Stovall, director of laboratory of hygiene, University of Wisconsin, Madison.

Thursday afternoon's session was devoted to a round table on hospital problems conducted by Dr. Bert W. Caldwell. Dr. Caldwell was assisted by Dr. K. H. Van Norman; Dr. W. A. Henke, chief of staff, Grandview Hospital, La Crosse, Miss Grace T. Crafts, R.N., superintendent, Madison General Hospital, Madison; Dr. R. C. Buerki, superintendent, Madison General Hospital, Madison; Miss Adda Eldredge, R.N., director of nursing, state of Wisconsin and president, American Nurses' Association; Mr. H. K. Thurston, assistant director, Jackson Clinic, Madison; and Miss Adah Patterson, R.N., superintendent, St. Luke's Hospital, St. Paul, Minn.

### Who Pays When Employees Are Sick?

The first question asked was "To what department should the expense involved in the care of sick nurses be charged?" The answers indicated that, generally speaking, the expense of care for sick nurses was charged to the nurses' training school. As to deductions from charges for the care of doctors, nurses, ministers, dentists, there seemed to be a great variation in the custom, varying from a ten per cent discount to all doctors, irrespective of whether they are doctors on the staff, and twenty per cent to clergymen and nurse alumnae, to fifty per cent for dentists, ministers and doctors. Most of the hospitals seem to allow no discount to trustees or their families. In a few instances the superintendent, the doctors and the lay staff pay full charges; the nurses and interns nothing.

In discussing the question of posting charges some of the hospitals stated they posted their charges as services are rendered. Others post the charges daily from forms sent by each department to the accounting department.

With regard to the preliminary training of student nurses it was generally thought that a high school training was essential to enable nurses to get the best out of their course.

The opening paper on Friday morning was presented by the Rev. H. L. Fritschel, director, Milwaukee Hospital, Milwaukee, and was devoted to a discussion of the planning of nurses' homes. This paper will be published in a later issue of THE MODERN HOSPITAL.

### Scope and Staff of Laboratory

The second paper on "The Organization of an Efficient Laboratory Service in the Hospital" was read by Dr. Edward L. Miloslavich, professor of pathology, Marquette University, Milwaukee. Dr. Miloslavich discussed the location, the organization and the personnel of the laboratory. He favored placing the laboratory on the main floor, near the room which serves as the conference room of the physicians. This location enables physicians to learn to respect the laboratory, to learn its capacity and limitations and to use it to better advantage. This position also makes the laboratory convenient to outside physicians. Dr. Miloslavich ruled against placing the laboratory in or near the operating suite or in the basement. In discussing laboratory organization he pointed out that the laboratory should be adapted to the work it has to perform and suggested four main divisions: (a) Clinical,

bacteriology and serology; (b) morphological analysis of blood; (c) clinical chemistry, analysis of urine and other body fluids; (d) pathological, microscopic study of tissue, etc.

For a hospital of one hundred beds Dr. Miloslavich suggested a minimum of three rooms and an additional room if possible for metabolism work.

In discussing the personnel of the laboratory Dr. Miloslavich contended that the head of the laboratory must be a physician who knows how to interpret and explain findings to the physicians. He also thought that a well trained, conscientious technician is the very life of the laboratory.

Whether the pathologist gives part time, half time or full time to the hospital depends not only on the character and size of the hospital but also on the work it has to do.

The concluding paper of this session was devoted to "Hospital Management from a Hotel Man's Viewpoint." This was prepared by Mr. Roy Watson, assistant general manager, Kahler Corporation, Rochester, Minn., and was read in his absence by Mr. Drummond. This paper will be published in a later issue of THE MODERN HOSPITAL.

### How Delegates Were Entertained

The conference was not without its social features. Wednesday evening a banquet was held in the crystal ballroom of the Hotel Loraine at which Colonel Joseph W. Jackson, director of Jackson Clinic, Madison, presided. Following the dinner addresses were delivered by Dr. M. T. MacEachern, president, American Hospital Association; Mr. John E. Ransom, superintendent, Michael Reese Dispensary, Chicago; Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, president-elect of the American Hospital Association and the Rev. J. W. Irish, executive secretary, Wisconsin Methodist Hospital and Homes Association, Madison, Wis.

Dr. MacEachern spoke on "The Fundamental Principles Involved in the Hospital Standardization Program;" Mr. Ransom on "The American Hospital Association—Looking Forward;" Mr. Gilmore on "The Development of Hospital Work During the Past Twenty-five Years" and Mr. Irish on "The Hospital's Function in the General Community Program."

Friday evening the delegates had a most enjoyable boat trip around Lake Mendota and on Friday afternoon were taken on an automobile tour in which the hospitals of the city were visited.

### Wisconsin Association Meets

The Wisconsin Hospital Association held its annual meeting in connection with the convention on Friday afternoon. The Rev. H. L. Fritschel was re-elected president; Dr. R. C. Buerki, superintendent, Wisconsin General Hospital, Madison, was chosen first vice president; Dr. Myron W. Snell, National Home for Disabled Volunteer Soldiers, Milwaukee, was elected second vice president and Mr. H. K. Thurston, assistant director, Jackson Clinic, Madison, executive secretary and treasurer; Mrs. Amelia C. Baird, Eau Claire, only member of the board of directors whose term expired, was re-elected for a term of five years. Other members of the board are: the Rev. H. L. Fritschel, Milwaukee; H. K. Thurston, Madison; Edward Freschl, Milwaukee; Dr. J. J. Bellin, Green Bay; Dr. W. A. Henke, La Crosse; and Dr. J. W. Coon, Stevens point.



# The Dominant Idea

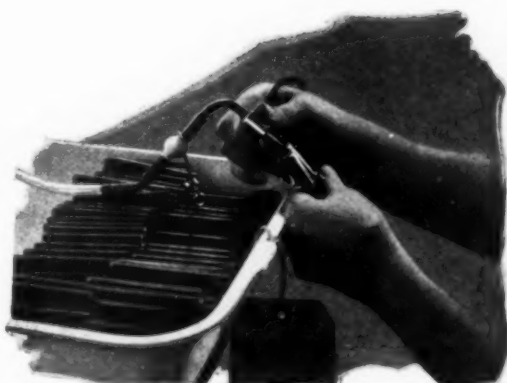


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## HOSPITAL SOCIAL WORKERS HOLD PROFITABLE ANNUAL CONFERENCE

THE program for the annual meeting of the Association of Hospital Social Workers, held at Toronto, Canada, June 25 to July 2, included three general sessions with excellent papers on "Social Ethics," "The Psychiatric Clinic and Psychiatric Social Work in a General Hospital," "The Place of Convalescence in the Public Health Organization," and a series of intensive round-table discussions which covered many subjects of interest to hospital social workers, such as social service records or histories, the organization and administration of social service in the small hospital, social treatment of cardiacs, the use of recreation as a method of social treatment, the organization of social treatment in rural mental health work, a discussion of books for social workers, training for hospital social workers.

At the annual luncheon, Miss Anne Cummins, lady almoner, St. Thomas' Hospital, London, England, told of hospital social service work in the hospitals in England. She spoke of the beginning of the work in 1895 through the introduction by Sir Charles Loch of a lady almoner into the Royal Free Hospital. She described the early struggles of the lady almoners, through a period of misunderstanding and misinterpretation, and their present general acceptance as an important and necessary part of hospital service, until today they are to be found in many of the hospitals throughout England.

High standards of training have been maintained, requiring two years of professional training with a university background; this training includes both theory and practice. Miss Cummins has found the experiences of hospital social workers in England and in America quite similar, with a common ideal of service.

### Purpose of Social Work Defined

Miss Lucy Wright and Dr. Richard Cabot discussed the "Philosophy of Social Work," and "The Ethical Approach to Problems of Social Work." Dr. Cabot offered the following definition of the purpose of social work: "To unblock and to keep open the channels of understanding between the client and worker, between the client and the family or friends, between agencies, between the agency and the public, between social groups, and between different parts of the client's own personality, in order that through these channels we may favor the entrance of the spirit and the bounty of God." The technique of social diagnosis and treatment is the digging and maintaining of such channels.

In social work, Miss Wright believes that we must choose between a concept that thinks of and treats any man's case in terms of the technique of the worker's own efforts, and a concept that thinks of and treats and interprets any man's case in terms of the art of living under the laws of life that are common to all of us. She feels that our own attitude is one of the few things in life within our control, and that this is largely influenced by our capacity for exchange of points of view.

Dr. Clarence O. Cheney who spoke on "The Psychiatric Clinic and Psychiatric Social Work in a General Hospital," brought out the similarity of problems in a hospital for mental diseases and in general hospitals. Much medical social work is not taken up from a psychiatric standpoint and thereby, Dr. Cheney thinks, fails to accomplish all that it might.

Reconstructive country health plants, to aid sub-standard humans back to healthful and efficient living, should be the next progressive step undertaken in the field of public health and welfare, stated Dr. Frederick Brush in his interesting talk on convalescence. Particularly important is this sort of extra hospital care to the psychoneurotic, the heart and tuberculosis cases, those recovering from serious illness and persons in need of vocational adjustment.

### How Social Service Helps the Convalescent

In discussing Dr. Brush's paper, Dr. Charles Hastings, Toronto, Ont., stated that there would be therapeutic value and an economic saving in releasing the patient from the four walls of the hospital, if this plan were more widely used, as the convalescent type of institution is maintained at approximately one-third the cost of the regulation hospital.

In the round table on the social treatment of cardiacs, Miss Elsie Wulkop, Massachusetts General Hospital, Boston, brought out the point that the success of social treatment depends on the excellence of diagnosis, prognosis and plan of treatment prescribed. The work of the medical social worker is strengthened because of three impressions made on the patient. First, the social worker is a colleague of the physician. Second, the worker makes a social diagnosis. Third, the worker has a recognized place in the medical institution and is invested with authority. Through study of the cardiac group, there is wide opportunity for social case work, material for research and preventive health work.

The section on psychiatric social work held its annual business meeting in Toronto. Mrs. Helen Anderson Young of St. Paul, Minn. was elected president of the section.

Miss Jarrett, retiring president of the psychiatric section, urged the continuance of the present form of organization, and the necessity of keeping ever before the members of the association the opportunity for maintaining and improving standards of training, and for developing educational and interesting literature for general distribution.

### Scope of Association Broadens

The report from the ten districts of the association, and the various standing committees show steady progress in the work and influence of the association. The fact that approximately three-hundred individuals are giving real service on district and general committees is an indication of the widespread participation of the members of the association in developing its policies and promoting its growth. There are 1158 members. Of this number 679 are active members and are employed as social workers in hospitals and dispensaries throughout the United States and Canada.

The officers and members of the executive committee for the year 1924-1925 are: president, Mabel Wilson, Children's Hospital, Boston, Mass.; first vice-president, Gertrude Farmer, Boston City Hospital, Boston, Mass.; second vice-president, Helen Anderson Young, St. Paul Dispensary, St. Paul, Minn.; third vice-president, Dorothy Ketcham, University of Michigan, Ann Arbor, Mich.; treasurer, Margaret S. Brogden, Johns Hopkins Hospital, Baltimore, Md.





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# CLOW

## BRITISH HOSPITALS ASSOCIATION HOLDS FOURTEENTH ANNUAL MEETING

THE fourteenth annual conference of the British Hospitals Association was held at Victory House, Leicester Square, London, June 20 and 21, under the presidency of the Hon. Sir Arthur Stanley, chairman, executive committee, British Red Cross Society. The 300 delegates present represented the chief hospitals in Great Britain. Sir Humphry Rolleston, president of the Royal College of Physicians, welcomed the representatives, and said in part that the policy of the association was to maintain the voluntary system as the best means for securing the well-being of the patients, the advance of medical and nursing education, and scientific research. The alternative is a system of complete state or municipal endowment and control.

The first paper read was by Dr. F. N. Kay Menzies, successor to the late Sir Napier Burnett, in the directorship of hospital and medical service, Joint Council of the Order of St. John of Jerusalem in England and of the Red Cross Society.

Dr. Menzies sketched in brief outline the extent to which provision is at present made for the treatment of disease in London. He pointed out that future developments in the poor law medical service might prove to be a big factor in the ultimate relationships of the voluntary hospitals and the municipal authorities.

### Urges Thorough Hospital Survey

Dr. Menzies urged a thorough survey of the whole hospital situation which would provide an unassailable basis upon which to build an adequate and coordinated scheme for the prevention and treatment of disease throughout the whole country. Dr. Menzies said that such a scheme, when drafted, should provide for (1) the preservation of the best features of the present voluntary hospital system; (2) adequate accommodation, equipment and finance of the hospitals generally; (3) the geographical distribution of hospitals so as to avoid unevenness and overlapping; (4) a closer relationship between voluntary hospitals themselves, between voluntary hospitals and various classes of hospitals provided by local authorities and between general practitioners and all the various institutions which treat the sick. The British Medical Association has given close attention to the same subject, the results of which have been published and a definite policy formulated. He brought out that it lay with the association to answer certain criticisms which had been made, such as, for example, that the voluntary hospitals lacked coordination.

### Voluntary System Challenged

On the evening of June 20 a dinner was given to the delegates at which Viscount Hembleden presided. Lord Stuart of Wortley, in addressing the association, said that British hospitals compared favorably with any the world had ever seen. He brought out that it was no secret that the voluntary system had been challenged and no longer stood as an undisputed axiom in the national life. Who would deny that contributions taken in the form of mass collections from the working classes carried with them representative functions on the board of governors? The only question was whether it would increase the resources of hospitals merely to call them government institutions.

The conference was continued on the morning of June 21, when Sir Arthur Stanley was re-elected president for the ensuing year. Announcement was then made that the council had appointed a small committee to cooperate with the voluntary hospitals commission which was making an inquiry in order that the whole position might be reviewed.

Mr. R. J. Meller spoke on the "Approved Societies in Relation to Voluntary Hospitals." The paper dealt with the question from the financial point of view and considered the situation from the aspect of the approved societies. He said that he represented a group of societies comprising over one-half of the insured population. Although he had no authority to speak for societies not within that group he knew from personal experience that the work of the hospitals was highly appreciated by them, and that there was the keenest desire to cooperate with them to the fullest extent.

Quite early in the career of the approved societies it became evident that the medical necessities of an insured population could not be met at the hands of the private practitioner only, and even today, twelve years after the coming into operation of the insurance act, a claimant demand was found for the extension of medical service.

### Extension of Constitutional Provision

He said that it was now recognized that hospital facilities were so superior that it was found necessary to provide accommodation for those who could not be admitted strictly within the conditions of the original constitution of the hospitals. There are in London and district, 117 hospitals; in the rest of England and Wales, 728, and in Scotland 107, making a total of 952. The beds available in London are approximately 12,797; England and Wales 31,265; Scotland 8,132; in all about 52,000 beds. There are, roughly speaking, fifteen million insured people, apart from the women and children who do not come within the scheme of national health insurance. It was estimated that the deficiency in the revenue required for the proper upkeep of the hospitals in Great Britain for 1921 was one million pounds sterling. These were striking figures and could not be ignored by the approved societies. If their contributions could increase the number of beds available or reduce the deficiency there was ample justification for the support which was now being given.

In reviewing the conference it may be said that no definite scheme was evolved by means of which the hospital system of Great Britain might be placed upon a more satisfactory basis than at present. However, the proposed survey of the hospital conditions throughout the country is a step in the right direction and should result in the formation of a working plan by which improvements will be introduced. While it may be possible to "run" the hospitals by voluntary effort, the building of new ones and the extensions continually required cannot be met from this source. The state or municipalities must assist. There seems to be no doubt that the approved societies do not fully recognize their responsibilities towards the hospitals, for there are still many which do not make a hospital grant and a growing number of persons who come forward for hospital treatment from whom no payment is received.



## WASHINGTON, PA. HOSPITAL WANTED \$500,000 FROM POPULATION OF 25,000

Ward, Wells, Dreshman and Gates solved the problem by Planning and Directing a Campaign June 16-23 in which \$523,000 was Obtained, and Developed Additional \$230,000 which will Soon be Realized

Washington, Pennsylvania, thirty miles from Pittsburgh, is a fine little city of about 25,000 people. Originally there were two small hospitals. A consolidation was made because of overhead expense. But this was unsatisfactory, principally because of lack of room and poor location.

When the directors of the hospital suggested a new larger and modern hospital there was a great division of opinion, and with other handicaps it seemed the hospital situation there would never be solved.

Bert Wells, one of the firm of Ward, Wells, Dreshman and Gates was invited to a conference with the directors. As a result a campaign was decided on and Wells directed it. At the end of the week of money-raising effort a total of \$523,000 had been subscribed. An additional \$50,000 will soon be realized, and an additional \$180,000 is definitely in sight, making the total to be credited to the campaign of more than \$750,000 in this little town of 25,000 people.

This is no doubt a record accomplishment, considering the size of the city.

We can cite scores and even hundreds of accomplishments as interesting, from one angle or another, as the above. These are your best assurance that we can solve the financial problems of your hospital.

There are hundreds of hospitals throughout the country that need the help we can give them.

Do as Washington did—get all the money you can use and in addition, make the people of the entire city a unit in supporting their hospital.

Our Quarterly Bulletin **FINANCING SOCIAL PROGRESS** gives further details and will be sent upon request

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When using advertisements see Classified Index, also refer to YEAR BOOK.

## CATHOLIC HOSPITAL ASSOCIATION HOLDS NINTH ANNUAL MEETING

A LARGE gathering of members of Sister nursing orders and other representatives of Catholic hospitals throughout the United States were in attendance at the ninth annual meeting of the Catholic Hospital Association of the United States and Canada held at Spring Bank, near Okauchee, Wis., from June 21-July 12. The first week's program was repeated the second week, as the facilities at Spring Bank are not sufficient to care for the entire attendance of the association at one time.

The first day was devoted to registration, reports of committees and conferences of various committee groups.

The meetings were presided over by the Rev. C. B. Moulinier, S. J., Milwaukee, Wis., president of the association, assisted by the Rev. P. J. Mahan, S. J., Chicago, Ill., vice-president. In opening the conference Father Moulinier called attention to the fact that the conference of the association differs from that of other hospital associations because of a distinct problem which the association is left to solve. He referred to the problem which is presented by the adjustment of the various orders of Sisters, working in groups as opposed to individual enterprise, and their relationship to the management of Catholic hospitals.

The program of the second day, exhibitors' day, was of special interest to the whole hospital field because of the problems of economics which were studied, particularly those relative to hospital purchasing and selection of equipment. The morning session was taken up with two papers, one on "General Economics of the Hospital," by Major Edward A. Fitzpatrick, of the Scanlan-Morris Company, Madison, Wis., and one on "Economy in Hospital Purchasing," by Mr. B. A. Watson, Crescent Washing Machine Company, Chicago, Ill., together with discussions and reports of the accounting and purchasing committees.

### Educational Role of the Salesman

Major Fitzpatrick turned attention to the educational mission of the salesman in instructing hospital people in economy in purchasing, for, as is generally evident in hospitals, economics is as yet little known to the hospital field. He made clear that economy is not synonymous with the lowest expenditure and that the lowest price paid for goods is not always the lowest cost. He applied this statement to the purchase of hospital equipment and cited examples to show that hospital purchasers had made costly mistakes in buying equipment at the lowest competitive price because they believed that low initial cost constituted economy.

In regard to equipment, he said that invariably the lowest priced articles were the most expensive in the long run, as the initial cost was but one factor in the actual cost of the article. He stressed the necessity of purchasers studying goods with a view toward their durability, as durable equipment nearly always proves to be quality products which bring the largest return. He believes that equipment should be the first consideration of a hospital and should not be deemed a minor expenditure, as it too often is, in hospital planning. He told of a million dollar hospital which was erected recently, the building program for which left but a comparatively small sum for equipping the hospital, with the result that the hos-

pital has a magnificent structure but has decidedly inferior equipment. He summarized by saying that he believed that economy consisted in selecting the best in materials, workmanship and construction.

In the discussion which followed, the subject of collective buying was brought up by two representatives from the eastern part of the country, one a hospital purchaser and the other a salesman, who agreed that collective buying had not proved successful in most instances where it had been tried in eastern hospitals.

### Principles of Economic Purchasing

Mr. Watson divided his paper into four parts which he considered the underlying principles of economy in purchasing. These are (1) the budget system; (2) record keeping; (3) economy in use; (4) collective buying. In discussing the problem from these four aspects he brought out that the budget system was an element essential to economy in purchasing, for there can be no economy where there is not careful analysis of both income and expenditure. He urged the continuous analyzing of past performances and the keeping of a definite chart of income and expenditure.

He gave as the important problems of purchasing (1) that all orders should be confirmed in writing; (2) that all purchases should be made on a competitive basis; (3) that a complete record of purchases should be kept as a basis for future purchases. He stressed the importance of having heads of departments in the hospital, such as the dietitian, technician, nurses, and surgeons, cooperate with the purchasing department. Speaking of standardization in equipment, he said that articles of special design should be avoided, as they are generally uneconomical. He also believes that there is such a thing as purchasing super-quality products—a practice which does not constitute economical purchasing.

He spoke against collective buying both in the interests of the hospital and the manufacturer. Collective buying, he emphasized, tends toward the survival of but two or three of the largest establishments. This brings about a condition of monopoly which, of course, does away with competitive buying and the benefits which the purchaser derives from this normal arrangement.

### Economy in Food Service Explained

The afternoon session was devoted to other economies in the hospital, the paper and discussions of which centered around economy in the buying and serving of food. An informal talk on "Purchase, Preparation, and Distribution of Food in the Hospital," was given by Mr. F. V. Baudissin, who has had many years of experience in working out this problem in various hospitals throughout the country. Mr. Baudissin said that many hospitals blunder in purchasing in futures, a practice which has proven uneconomical with respect to many food supplies. He said that in many hospitals where he has had charge of reorganizing the purchasing and handling of food, he has found cases of canned goods over two years in the hospital. He brought out that canned vegetables and fruits should not be kept in the hospital for long periods, as they become poisonous, and urged against keeping a large quantity of foodstuffs on hand, as this practice works against economy.



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Mr. Baudissin explained in detail his work in reducing the cost of food service in the various California hospitals. He goes about surveying hospital food departments, checking costs, and methods of service, and then makes a proposition to the hospital of saving thousands of dollars a year by a reorganization of the department. He referred to two San Francisco hospitals where from \$65,000 to \$70,000 are being saved yearly through such a reorganization.

In the discussion which followed, Mr. A. E. Merrill, managing engineer, Albert Pick and Company, Chicago, Ill., explained the relationship of the planning of the kitchen to economy in the placing of equipment. He believes that the planning of the kitchen should be left in the hands of an expert engineer, as the majority of architects consider the planning of the kitchen of secondary importance. He went into details in comparing the durability of materials in stoves, sinks, kettles and other kitchen equipment and warned against purchasing cheap materials.

The morning session, July 2, was opened by a paper on "The Value of a Reasonably Uniform Technique in the Various Departments of the Hospital," prepared by Sister M. Rose, Mercy Hospital, Pittsburg, Pa. Sister Rose emphasized the need for standardization of technique for student nurses so that there will be closer correlation between what the student is taught in the classroom and practical work on the floors. She made a plea for a simple technique throughout the hospital to facilitate in changing nurses from one department to another, and suggested that a reasonably uniform and standardized technique be adopted through the study of the best methods which are already in practice.

In the discussion which followed this paper, Dr. Wyse, Pittsburgh, Pa., advocated that each hospital have an individual printed text book embodying the technique of the hospitals in regard to what is expected of the patient and the technique expected of physicians, surgeons and nurses. Sister Helen Jerrell, St. Bernard's Hospital, Chicago, Ill., strongly advised the complete equipment of a demonstration room on each floor of the hospital.

An address on "General Education of Hospital Sisters," was given by the Rev. Albert C. Fox, president, Marquette University, Milwaukee, Wis. "In our hospital nursing," Father Fox said, "There has been too much insistence on training and too little on education. The stride which nursing education has taken the past few years means that teachers in nurse training schools must have higher educational qualifications." He pointed to the training schools in connection with educational institutions, such as Yale and Columbia, and said that public opinion was in favor of nursing education such as these schools offer. He spoke of the new school of nursing which Marquette University is to have along the same lines as the other university schools for both the training of student nurses and for advanced work of the sisters engaged in the teaching of nursing. The arrangements at Marquette University will combine two years of college work with three years of nursing, leading to the bachelor of science degree at the end of five years.

Dr. L. D. Moorhead, Mercy Hospital, Chicago, Ill., in discussing the problem of the superintendent and the training school emphasized the responsibility of superiors in choosing from the community those sisters best fitted to be in charge of nursing schools.

The exposition hall was filled with over 1,800 square feet of commercial displays of hospital equipment and supplies, as well as booths of hospital publications and one of the Hospital Library and Service Bureau.

## INTEREST CENTERS ON A. H. A. BUFFALO CONFERENCE PLANS

(Continued from page 142)

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(American plan)	\$5.00 up double
Hotel Lafayette	Men's Hotel
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\$3.50 up single	\$1.00 up single
\$4.00 up double	\$2.00 up double
Hotel Graystone	Hermitage hotel
—15 rooms	—30 rooms
\$5.00 up double	\$4.00 up double
	Niagara Hotel
	—40 rooms
	\$2.00 up single
	\$5.00 up double

## NEW ENGLAND HOSPITAL ASSOCIATION MEETS

The annual meeting of the New England Hospital Association was held in the Boston Medical Library, Boston, Mass., May 21 and 22, 1924. The following papers covering various phases of hospital administration were presented:

"Some Aspects of Hospital Economics," by Dr. William O. Rice, assistant superintendent, Rhode Island Hospital, Providence, R. I.; "A Consideration of Factors Important in Stimulating and Promoting Hospital Interdepartmental Cooperation," by Dr. B. Henry Mason, assistant superintendent, Peter Bent Brigham Hospital, Boston, Mass.; "Hospital Accounting," by Mr. Egbert E. Stackpole, Massachusetts General Hospital, Boston, Mass.; "Fire Prevention and Protection for Hospitals," Dr. George H. Stone, superintendent, Eastern Maine General Hospital, Bangor, Me.; "Relation of the Hospital to Public Health," by Dr. Charles V. Chapin, superintendent of health department, City of Providence, Providence, R. I.; "Essentials of the Education of the Nurse to Meet Modern Needs," by Miss Lucy C. Ayers, R.N., superintendent, Woonsocket Hospital, Woonsocket, R. I.; "Hospital Noises and How to Minimize Them," by Mr. Edward F. Stevens, F.A.I.A., of Stevens and Lee, Architects, Boston, Mass.; "Immunization of Nurses in Training Schools," by Dr. George P. Sanborn, Boston, Mass.; and "What Shall the Patient Pay," by Dr. Henry M. Pollock, superintendent, Massachusetts Homeopathic Hospital, Boston, Mass.

The following officers were elected for the ensuing year: president, Dr. George H. Stone, superintendent, Eastern Maine General Hospital, Bangor, Me.; vice-president, Dr.





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Thomas S. Brown, superintendent, Mary Fletcher Hospital, Burlington, Vt.; and treasurer, Dr. George A. MacIver, assistant director, Massachusetts General Hospital,

Boston, Mass. Miss K. M. Prindle, superintendent, Lawrence and Associated Memorial Hospital, New London, Conn., was elected trustee.

## MISSOURI HOSPITAL ASSOCIATION HOLD THIRD ANNUAL MEETING

THE third annual meeting of the Missouri Hospital Association was held in McAlister Hall of the medical school, University of Missouri, Columbia, June 25, 1924. The meeting was presided over by Dr. Rush E. Castelaw, president.

At the morning session, Dr. Guy L. Noyes, dean of the state university medical school, University of Missouri, Columbia, spoke briefly on the problems of the proper care of the sick in rural communities and urged that the growth of well-managed country and county hospitals should be promoted throughout the state.

The following problems were presented by the president and discussed by those present at the morning session: the best time and place to hold the meeting; the question of a permanent secretary and treasurer; the general decrease in hospital business throughout the state; how the association could be strengthened and a wider interest taken in the meetings.

The afternoon was given over to visiting the Boone County Hospital, the Parker Memorial Hospital and the university campus.

### Problems Discussed in Round Table

The evening session consisted of a dinner followed by a round-table discussion and a short business session.

In the round-table discussion, the following problems were considered: (1) Present business conditions as they relate to the hospital field; (2) the benefit derived from the minimum standard demanded by the American College of Surgeons; (3) methods of protecting hospitals from individuals who enter as patients with no intention of paying their accounts; (4) Should patients able to pay a part of their bill be required to do so in charity or municipal institutions?; (5) Have hospitals reduced their charges since the high prices of 1919 and 1920?; and a general consideration of the educational requirements of pupil nurses.

The question of increased membership in both the state association and the American Hospital Association was discussed by Dr. L. H. Burlingham, Barnes Hospital, St. Louis.

The resignation of Dr. Louise Aments, treasurer, was accepted, and the following were elected to active membership; Miss Sadie Hausmann, Parker Memorial Hospital, Columbia; Miss Estella Claybourne, Shriners' Hospital, St. Louis; and Miss L. A. M. Bennett, Children's Hospital, St. Louis.

The following were appointed on the nominating committee by the president: Mr. E. P. Haworth, Willows Sanitarium, Kansas City; Miss Eleanor Keeley, Boone County, Columbia; and Miss L. A. M. Bennett, Children's Hospital, St. Louis. Mr. W. J. Grolton, Missouri Pacific Hospital, St. Louis, and Miss Estella Claybourne were appointed on the auditing committee.

### Dr. Castelaw Reelected President

Dr. Rush E. Castelaw was elected president of the association for the coming year. The other officers elected

were: B. A. Wilkes, first vice-president; Emma H. Bechtol, second vice-president; W. J. Grolton, secretary, and Estella Claybourne, treasurer. Dr. Guy L. Noyes and Miss Isabelle Baumhoff were elected to succeed themselves as trustees. The other members of the board are Dr. Rush E. Castelaw, chairman; Miss Mary G. Burman, Dr. M. O. Biggs, and Dr. L. H. Burlingham.

St. Louis was selected as the place for the next meeting to be held in May, 1925. Consideration was given to the suggestion of holding a joint meeting with the Illinois association, but no definite action was taken on this matter.

## NATIONAL CONFERENCE OF SOCIAL WORK HOLDS FIFTY-FIRST MEETING

The fifty-first annual meeting of the National Conference of Social Work, of which the American Association of Hospital Social Workers is a section, was held at Toronto, Ont., June 25-July 2.

Papers and discussions at the conference showed a changed interpretation of child health. Child care, in particular, is being strengthened in its preventive rather than its corrective aspects. Through the efforts and study of Dr. Helen T. Wooley, chairman of the children's section, much has been done in the way of teaching the socially unfavored child how to live.

A scheme for the elimination of all criminals capable of reclamation from the "catch-all" prison was given by Dr. Ellen C. Potter, commissioner of public welfare, Harrisburg, Pa.

The health section program was devoted to the educational phases of maternity and infant welfare work which now have the advantage of state aid. Technic was outlined for the special educational problems in combating venereal disease, and an approach was made to the racial health problems of the negro element of our population.

An interesting sidelight on the trends in methods of administration is shown by the fact that 200 community chests will this year administer \$50,000,000.

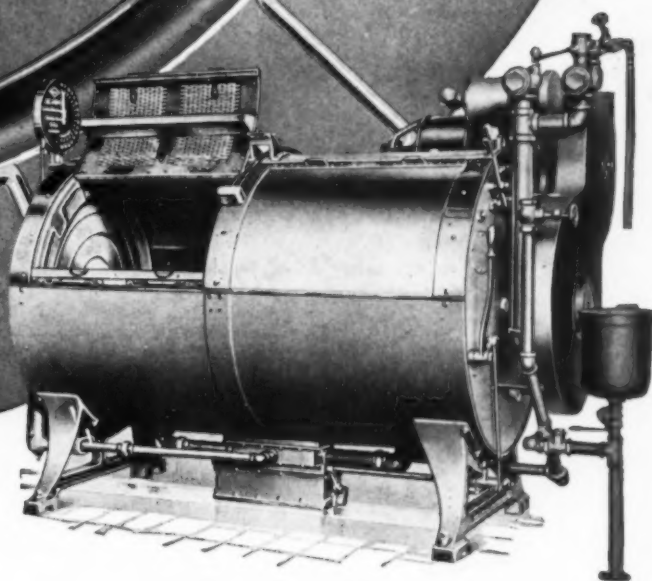
A conference of editors of social publications was held under the chairmanship of James A. Tobey, National Health Council. The conference resulted in the establishment of a permanent organization, and regular meetings are to be scheduled with the American Public Health Association and with the Council on Medical Education and Hospitals of the American Medical Association.

The officers elected for the coming year are: Mr. W. J. Norton, Detroit, Mich., president; Dr. Helen T. Wooley, Detroit, Mich., first vice-president; Mr. J. Prentiss Murphy, Philadelphia, Pa., second vice-president; and Mr. George W. Kirch, New York, N. Y., third vice-president. The board of directors is composed of Miss Edith Abbott, Chicago, Ill.; Mr. James F. Jackson, Cleveland, Ohio; Mr. Eugene O. Johns, New York, N. Y.; Miss Julia Lathrop, Washington, D. C.; and Mr. Robert A. Woods, Boston, Mass.

The next meeting of the association will take place in Denver, Col.



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# NEWS OF THE HOSPITALS AND SANATORIUMS

*The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.*

## General

**Hospital Bequests and Donations.**—The following hospital bequests and donations have recently been announced:

Beth Israel Hospital, New York, N. Y., \$500, by Fannie F. Rosen.

Minnesota Public Health Association, \$5,000 by A. R. Brown, Minneapolis.

Children's Home, Parsippany, N. J., \$500, by the Morris County Medical Society.

Victory Memorial Hospital, New York, \$150,000 from the Rockefeller Foundation.

St. Raphael's Hospital, New Haven, Conn., a second \$100,000 by Truman S. Lewis.

St. Luke's Hospital, New Bedford, Mass., \$200,000 under the will of Thomas S. Hathaway.

Hudson, Mich., residence to be used as a community hospital, by the will of Mrs. Ellen Thorn.

Abington (Pa.) Memorial Hospital, \$16,451 by the Huntingdon Valley County Club members.

Charity Hospital, New Orleans, La., \$20,744 to cover the deficit in the hospital fund, by T. H. McCarthy.

Shonghum Sanatorium, Morristown, N. J., a medical library, donated by Dr. A. E. Carpenter, Boonton.

St. Luke's and Samaritan Hospital, Philadelphia, Pa., \$3,000 each under the will of Harry W. Freudenheim.

West Baltimore General Hospital, Baltimore, Md., a room in memory of his father, by Dr. Arthur G. Barrett.

Houston, Texas, for the erection of the Autry Memorial School for Tuberculous Children, \$50,000 by Mrs. Allie K. Autry.

Homeopathic Hospital, Newark, N. J., \$40,000 anonymously and \$1,500 for the establishment of a bed, by Colonel Austen Colgate.

Methodist Episcopal Hospital, Indianapolis, Ind., \$25,000 for the endowment of the maternity ward by Mr. and Mrs. William H. Coleman, Indianapolis.

Albany General Hospital, Albany, Ore., \$2,000 for the equipment of a surgery which will be known as the J. P. Wallace Surgery, by Dr. James P. Wallace.

St. Luke's Hospital, St. Louis, Mo., a tract of 134 acres of land and buildings at Crescent for the use of convalescent patients and sufficient money for the care and upkeep of the buildings and grounds, by Mrs. George W. Brown.

It will be known as the George Warren Brown Farm, in memory of her husband.

**New Superintendents.**—The following new superintendents have recently been announced: Perry Memorial Hospital, Princeton, Ill., Miss Evadine Alexander; Sullivan County Hospital, Sullivan, Ind., Mrs. Alma Erickson; Massie Memorial Hospital, Paris, Ky., Miss Lelah D. Gibson; Holyoke City Hospital, Holyoke, Mass., Miss Margaret E. Conrad; Hope Cottage, Florence Crittenton Home and Hospital, Swampscott, Mass., Miss Florence M. Ripley; Binghampton State Hospital, Binghampton, N. Y., Dr. William C. Garvin; District Tuberculosis Hospital, Lima, Ohio, Dr. J. G. Place, Jr.; Mercy Hospital, Altoona, Pa., Miss Mary Whitney; St. Luke's Hospital, Bethlehem, Pa., Mr. C. Calvin Davis; State Tuberculosis Hospital, Hopemount, W. Va., Dr. G. F. G. Pettit; Madison General Hospital, Madison, Wis., Miss Grace Crafts.

**Hospitals and Additions Recently Opened.**—The following hospitals and additions have recently been opened: First wing of the new home for the Children's Hospital, Birmingham, Ala.; Nye-Hodge Hospital, Scottshorn, Ala.; new nurses' home for the French Hospital, San Francisco, Cal.; addition to New Britain General Hospital, New Britain, Conn.; Morgan County Memorial Hospital, Martinsville, Ind.; Southwestern Hospital, Wichita, Kan.; Mercy Hospital, New Orleans, La.; Gogebic County Public Hospital, Bessemer, Mich.; Ingham Hospital, Lansing, Mich.; New Home for Missouri Methodist Hospital, St. Joseph, Mo.; New Reception Hospital for Pokegama Sanatorium, Pokegama, Minn.; Baptist Hospital, Charlotte, N. C.; Davidson Hospital, High Point, N. C.; Hunts Point Hospital, New York, N. Y.; Coudercroft Baby Sanatorium, El Paso, Texas; Pacific Christian Hospital, Eugene Oregon; Yoghurt Sanitarium, South Bellingham, Wash.; new wing to St. Luke's Hospital, Spokane, Wash.; new building for Wisconsin General Hospital, Madison, Wis.

## Arkansas

**Little Rock to Have Four New Hospitals.**—Four new hospitals are to be erected in Little Rock during the next year: the Missouri Pacific Hospital, which will accommodate 120 patients; the Baptist Hospital, the sixty bed Children's Hospital; and the Trinity Hospital, which will have fifty beds.

## California

**To Superintend Glendale Sanatorium.**—Dr. Archibald W. Truman, Washington, D. C., has been appointed medical superintendent, Glendale Sanatorium, Glendale, to succeed Dr. Henry G. Westphal.

**Hollywood to Have New Hospital.**—Hollywood Mineral Springs, Inc., has just purchased the old Radium Springs





**FREE** SAMPLE TO NURSES  
Clip and Mail Coupon Below



## Solving Woman's Oldest Hygienic Problem in a New Way

*Recommended by nurses, hospitals, health authorities—assuring  
millions of women immaculacy, charm, peace of mind*

By ELLEN J. BUCKLAND, Graduate Nurse

This tells of a new way in personal hygiene. A way which gives immaculacy, exquisiteness, safety. It supplants old-fashioned "sanitary pads" and other sanitary methods.

Discovered by nurses in France during the war, this new way has proved a benefit to all womankind. Today 8 in 10 women in the better walks of life have adopted it. Once tried no other method will satisfy.

This new way is called Kotex. Foremost doctors advise it. Leading hospitals, health officials, industrial and social service nurses are telling women everywhere of the new freedom—the daintiness, assurance and poise—it brings under circumstances which women find exceedingly trying.

### Let women know

Kotex assures the extreme of sanitation, personal comfort and protection—with delicate regard for the niceties of daily life. It is a good health habit.

That is why you should recommend it in schools, colleges, factories, hospitals—wherever women congregate. Women appreciate this counsel.

They value your professional knowledge—your intimate advice which leads to radiant health. You are performing a noteworthy service when you tell them of the exclusive advantages of Kotex. The nurse who gives helpful service is the successful nurse—she develops an enthusiastic following.

It is but natural that you should sponsor Kotex. As a public health measure, urge the installation of Kotex Cabinets in rest-rooms, in offices and public buildings.

Women who spend one-sixth of their time in a state of embarrassment, and often fear, welcome the word of the nurse who reveals to them this new, scientific way.

Tell them how easily they may dispose of Kotex. Just like a piece of tissue. No embarrassment, no difficulty—a point all women appreciate. It means new freedom in all social and business activities, especially when away from home.

Let women know that Kotex is made of Cellucotton—the super-absorbent. It is 5 times more absorbent than ordinary pads. Kotex absorbs 16 times its own weight in moisture instantly.

Kotex comes ready-prepared, ready for immediate use, in plain packages of 12 soft, fluffy, sterile folds. Women like its smooth, non-chafing coolness, its delightful comfort—something they have never known before.

### Ask for it by name

Obtain Kotex at your nearest drug store, without embarrassment. Simply ask for it by name. It comes in two sizes—regular and Kotex-Super.

As a nurse, as a woman—I feel that every nurse should try Kotex, at least. If you have never used this new way yourself, write me for the nurses' free test. Sent postpaid in plain, unmarked envelope. If you wish, I will send you a free copy of the new book—"Personal Hygiene for Women." Simply fill in coupon and mail to me, personally.

A trial of Kotex proves its amazing advantages.

# KOTEX



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M. H. 8-24

Care of Cellucotton Laboratories  
166 W. Jackson Boulevard, Chicago

I want to accept free trial offer with the understanding that it is absolutely confidential. Please send me in plain envelope—

☐ Book on Personal Hygiene. ☐ Sample of Kotex.

Name .....

Address .....

City ..... Hospital .....

When using advertisements see Classified Index, also refer to YEAR BOOK.



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We are serving hundreds of hospitals and can satisfactorily take care of your linen marking problem if you will write us.

**APPLEGATE CHEMICAL COMPANY**  
5630 Harper Avenue, Chicago



property, Hollywood, for the site for a seven-story hospital to be erected at a cost of \$750,000.

**Reid Sanatorium Swept by Fire.**—The Reid Sanatorium, Tuolumne, was swept by fire, July 4, when the upper stories were burned and the lower part badly damaged. The blaze started in the garret and was probably caused from defective wiring. The loss is estimated at \$6,000.

**Dr. Wayte to Norwalk State Hospital.**—Dr. Edwin Wayte, assistant superintendent, Southern California State Hospital, Patton, has been appointed medical superintendent in charge of the Norwalk State Hospital, Norwalk, to succeed Dr. Charles F. Applegate, who recently resigned.

### Colorado

**Plan \$100,000 Community Hospital for Boulder.**—The Chamber of Commerce, Boulder, recently approved plans for the construction of a \$100,000 community hospital for that city.

### Georgia

**Dr. Steedy to Direct Steiner Cancer Clinic.**—Dr. Benjamin B. Steedy has been appointed director of the new Steiner Cancer Clinic, Atlanta, in connection with the Brady Hospital. The Steiner Clinic building was made possible by the will of the late Albert Steiner, who left a fund of \$500,000 for the erection and maintenance of the building.

### Illinois

**Keystone Hospital to Have New Nurses' Home.**—Bids have been taken for the erection of a \$15,000 nurses' home for the Keystone Hospital, Chicago.

**To Superintend Oaklawn Sanatorium.**—Dr. Bert Tripper has been appointed superintendent of Oaklawn Sanatorium, Jacksonville, to succeed Dr. Francis M. Roberts.

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**Campaign for Nurses' Home.**—A campaign to raise \$50,000 to pay off indebtedness on the nurses' home, and for the purchase of a new boiler for the heating plant, is being carried on by the Decatur and Macon County Hospital, Decatur, Ill.

**Mother Cabrini Memorial Hospital Opened.**—The new Mother Cabrini Memorial Hospital, Chicago, was recently dedicated by Cardinal Mundelein. The hospital is a seven-story structure which will supercede the Columbus Extension Hospital. Transfer of patients took place June 23.

**Proposed \$10,000,000 Hotel-Hospital for Chicago.**—Announcement has been made of the tentative plans for the proposed \$10,000,000 hotel-hospital which is to be erected in Chicago by a group of physicians and surgeons, as the medical center of the West. According to plans, the diagnostic hotel-hospital will be twenty-four stories high and will contain 800 rooms. The site will soon be selected and construction will be begun this year.

The Physicians' and Surgeons' Institution will be conducted on lines similar to that of the Mayo Foundation, Rochester, Minn. The institution will be primarily for the





MARY FRANCES KERN

## Financial Standing

The very first question asked in the business world is—"What is the financial standing?" For obvious reasons, the rating of the campaign organization which serves you is of vital importance. THE KERN ORGANIZATION has an established financial reputation in the business world as high and definite as the record of its many campaign successes. The credit organizations and leading banks give the highest opinion of the responsibility of THE KERN ORGANIZATION.

The KERN ORGANIZATION invites prospective clients to investigate this financial standing thoroughly, as well as its ethics, its efficiency, its methods. Only on the basis of complete satisfaction and perfect understanding can the best results be achieved.

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1340 Congress Hotel  
CHICAGO, U. S. A.

256 BROADWAY  
NEW YORK CITY

308 COLONIAL BLDG.  
TORONTO P. O., CAN.

## A New Way— to secure ideas

You can know and check against what other hospitals do. Our men are traveling "trade papers"—sources of valuable information.

How does your cost per bed per day compare with that of other hospitals in this territory? Is there a waste in your current expenses—or too big a surplus in certain supplies? Do you know?

Here is a way to check your figures against the figures and methods of other hospitals.

When the Palmolive salesman calls, think of him as a valuable source of information. He knows of the successful and unsuccessful methods tried in other hospitals. He has at his finger tips facts and figures about ways and savings of the most successful hospitals everywhere. Specific information—on costs—how stewards manage to lower them. Many of new, practical ideas he brings may save dollars for you.

He will do this without mentioning names or violating confidences. He is a gentleman. You will find him interesting, intelligent, a valuable "trade paper" of information.

So when his card comes to your desk think of him in this way first.

He is a soap expert too, and the extra information he has on soap and sanitation may well prove as valuable as the rest.

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## Save Time and Money By Indelible Marking of Your Hospital Linen

We are serving hundreds of hospitals and can satisfactorily take care of your linen marking problem if you will write us.

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He is a soap expert too, and the extra information he has on soap and sanitation may well prove as valuable as the rest.

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**ALL HOSPITALS**

SHOULD WRITE TO OUR

**A. L. COSTELLO**

(HOSPITAL AND INSTITUTION DEPT.)

for estimates before placing  
their orders for**HOSPITAL SUPPLIES  
And FURNISHINGS**Hospital Beds, Rugs,  
Furniture, Curtains,  
Blankets, Linens,  
Bedding, Silverware,

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Blankets, Sheets and Pillow Cases in Case  
Lots shipped direct from mill.Special attention given to Nurses' Uni-  
form materials.**John V. Farwell Company**  
**CHICAGO**

102 SOUTH MARKET STREET

Importers—Manufacturers—Wholesalers

**MOST WELL CONDUCTED HOSPITALS  
USE OUR****Record and Account Books  
AND  
Hospital Charts**

Our catalog number sixteen fully illustrates the latest ideas in hospital recording and accounting, and contains samples of the charts recommended by the American College of Surgeons, as well as others which have been in use many years by leading hospitals.

**The Burkhardt Company, Inc.**

545 Larned St. West

**DETROIT, MICHIGAN**

diagnosis of disease and half of the proposed building will be a hotel where out-of-town patients, relatives and friends may stop while waiting admission to the hospital. Plans for the first unit to cost \$5,000,000 have been drawn by Louis Genzel, Chicago architect.

**Cornerstone of Austin Hospital Laid.**—The cornerstone of the Austin Hospital, across from Columbus Park, Chicago, was recently laid. The new hospital, which is to be erected at a cost of \$1,000,000, is to be built in the shape of an "X" so that every room will be an outside room. Every room is to be equipped with a private bath, radio connection, and other services which tend to make the new hospital a combination hotel-hospital. There are to be 210 beds with provision for future expansion up to 340 beds.

**Indiana**

**Madison County Tuberculosis Hospital Dedicated.**—The Madison County Tuberculosis Hospital, Anderson, was dedicated June 29.

**Plan James Whitcomb Riley Hospital for Children.**—A \$2,500,000 hospital for children is being erected in Indianapolis, by the state and admirers of James Whitcomb Riley. The hospital is to be opened some time in September, according to announcement.

**Vanderburgh County Tuberculosis Hospital to Enlarge.**—Improvements and additions to the Vanderburgh County Tuberculosis Hospital, Evansville, to cost approximately \$655,000 are being planned. The improvements will include the construction of wards for convalescents, children's wards, a nurses' home, and a power plant, as well as new equipment.

**Major Memorial Hospital Opens.**—The Major Memorial Hospital, Shelbyville, was opened to the public June 18. A building and grounds for this hospital valued at \$75,000 were bequeathed by the late William S. Major. The buildings and nurses' home, valued at \$150,000, have been constructed. Miss Clara Widdifield, formerly of the City Hospital, Indianapolis, is superintendent of the hospital.

**Iowa**

**Dr. Meggers to Superintendent Clark Hospital, McGregor.**—Dr. Edward C. Meggers, Prairie du Chien, Wis., has been appointed manager of the Clark Hospital, McGregor, to succeed Dr. Henry H. Clark, who founded the hospital twenty-two years ago. Dr. Clark is retiring from active service.

**Kentucky**

**Tuberculosis Hospital Enlarged.**—The Hazlewood State Tuberculosis Sanatorium, Louisville, is open for the reception of fifty more patients following the completion of improvements giving the hospital a total capacity of 100 beds.

**Louisiana**

**Dr. Rucker to Have Charge of Marine Hospital.**—Dr. W. C. Rucker, surgeon, U. S. Public Health Service, is to take charge of the new marine hospital in New Orleans.

**Plan Eight-Story Baptist Hospital.**—A new Southern Baptist Hospital is being planned for New Orleans. The hospital will have eight stories. The first unit to be constructed this year will be the central building which will cost approximately \$500,000.

Dr. Louis J. Bristow, now superintendent, Baptist Hospital, Selma, was elected superintendent of the new hospital at New Orleans, at the recent meeting of the Southern Baptist Hospital Commission.



Quality and Safety  
are combined in the new—

# Eastman *Safety* Dupli-Tized X-Ray Films *Super-Speed*

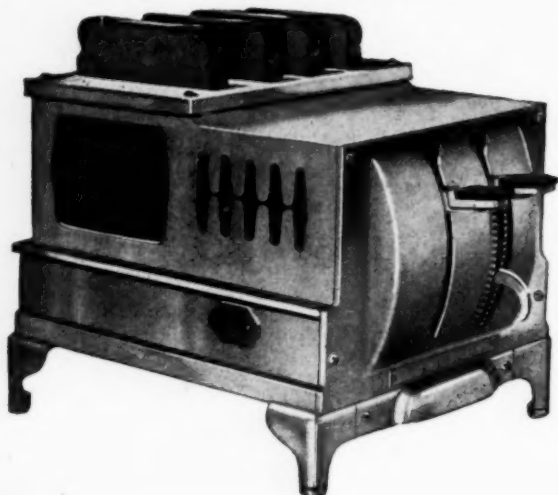
This new material is identical in every respect but one with the well known Eastman Dupli-Tized X-Ray Films. *Safety Films* have as their base cellulose acetate and may be stored in files exactly as you store your paper records—and with no greater fire hazard. This new film has been developed particularly for use in hospitals and other places where it is difficult to take the precautions necessary for proper storage of the regular X-Ray films.

Eastman Kodak Company

*Medical Division*

Rochester, N. Y.

NO WATCHING—NO BURNING



## Makes Perfect Toast Automatically!

The TOASTMASTER now solves your toast problem once and for all. With it in your diet kitchens, you can give your patients toast *always* fresh and hot, and evenly browned. The 4-slice size makes over a dozen orders every ten minutes, *without watching—without burning one piece.*

## The Strite TOASTMASTER Automatic Electric Toaster

**PLEASES PATIENTS.** Gives the toast a flavor unequalled by any other method of toasting. Thoroughly dextrinizes toast.

**SAVES TIME.** Toast pops up when done, current automatically shuts off, requiring no attention from nurse while toasting. Oven heat keeps toast *hot* until served. No scraping. No re-toasting.

**SAVES BREAD.** Adjustable timing to toast any bread, fresh or dry.

**CURRENT COST LOW.** Enthusiastically endorsed by scores of hospitals using it. A 12-slice size also, for your main kitchen. Write nearest sales office or direct to us for full information.

### Waters-Genter Co.

34 N. 2nd St. Minneapolis, Minn.

Chicago Sales Office: 123 W. Madison St.

Western Sales Office:

14 Montgomery St., Room 505, San Francisco

Eastern Sales Office:

HECTOR C. ADAM, INC., 342 Madison Ave.,  
New York, N. Y.

**SOLVES YOUR TOAST PROBLEM**

### Maryland

**To Superintend Sheppard and Enoch Pratt Hospital.**—Dr. Arthur E. Pattrell, executive officer, Boston Psychopathic Hospital, has assumed his duties as superintendent, Sheppard and Enoch Pratt Hospital Towson.

**West Baltimore Hospital Dedicated.**—Dedication services for the West Baltimore General Hospital, Baltimore, were held June 12-13. The hospital contains 150 beds and is located on the grounds of the old Hebrew Orphanage, South Walbrook.

**State Appropriation for Hospitals for the Mentally Ill.**—The general assembly of Maryland has appropriated \$667,000 this year for the state hospitals for the insane and feeble-minded. New structures are being planned at all state hospitals. At Springfield, a building increasing the capacity of the hospital by fifty beds; at Spring Grove Hospital, a wing to the Foster Clinic which will accommodate 100 patients; and provision for 100 additional feeble-minded children at Rosewood State Training School by erection of a \$100,000 dormitory.

### Massachusetts

**Bullfinch Building to Be Enlarged.**—The Massachusetts General Hospital, Boston, is planning the enlargement of the Bullfinch building.

**Dr. Coolidge Leaves Lakeville Sanatorium.**—Dr. Sumner Coolidge, for the past fifteen years superintendent, Lakeville State Sanitarium, Middleboro, has resigned his position.

**Boston City Hospital Plans Maternity Building.**—A 100 bed maternity building is being planned by the Boston City Hospital, as a part of the expansion program for which the legislature has authorized the raising of \$3,000,000.

**To Superintend Union Hospital.**—Mr. James R. Mays, former superintendent, Garfield Memorial Hospital, Washington, D. C., has resigned his position to become a superintendent, Union Hospital, Fall River. Col. Dean C. Howard, U. S. A. Medical Corps, retired, will superintend the Garfield Memorial Hospital.

**Cooley-Dickinson Hospital Plans Expansion.**—The Cooley-Dickinson Hospital, Northampton, is planning a number of alterations to the existing plant and the erection of a new maternity pavilion. The hospital has engaged Mr. Charles F. Neergaard, hospital consultant, New York, N. Y., to study the community's needs and prepare a program for the future activities of the hospital and alterations to the existing plant.

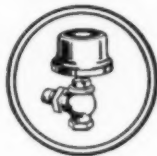
### Minnesota

**Seven Glen Lake Sanatorium Units Opened.**—The seven new units of Glen Lake Sanatorium, Minneapolis, were opened on June 7. The new units have a capacity of 350 beds, bringing the total bed capacity of the institution up to 600. Each new bed has been provided at a cost of \$4,000.

**Minneapolis General Hospital Opens to Women Interns.**—The General Hospital, Minneapolis, has announced that it will open its doors to women interns. Up to the present time the hospital has not admitted women interns on the grounds that they were not physically fitted for the work required.

**Minnesota General Hospital Enlarges.**—The enlargement of the Minnesota General Hospital by 100 beds was commenced June 18, when work on the Todd Memorial Hospital and George Chase Christian Memorial units was begun on the campus. Dr. Louis B. Baldwin, superintendent, University Hospital, expects that the new buildings will be ready for use by September, 1925. A gift of





## Theda Clark Memorial Hospital, Neenah, Wisconsin

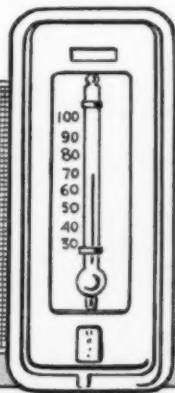
is equipped with The Johnson System of Temperature Control. The satisfaction and results this hospital announces as having secured from The Johnson System induces the president's opinion that "it is a feature which should be considered in all new hospital construction." The fuel saving of from 15 to 35 per cent annually and the reliable control of temperature is particularly specified for each room and part of the hospital are the reasons for its necessity. The advanced design, materials, construction and installation distinguishing The Johnson System as best are why The Johnson System is the one to install. No hospital should be without it.

*Johnson valves, damper motors, etc. have the celebrated "Sylphon" diaphragm and bellows—which are of metal and are seamless. The Johnson System is the only one thus furnished. This company maintains its own branches in 28 principal cities of United States and Canada: of Johnson's own administration, engineers, mechanics, materials, standards and Johnson Service.*

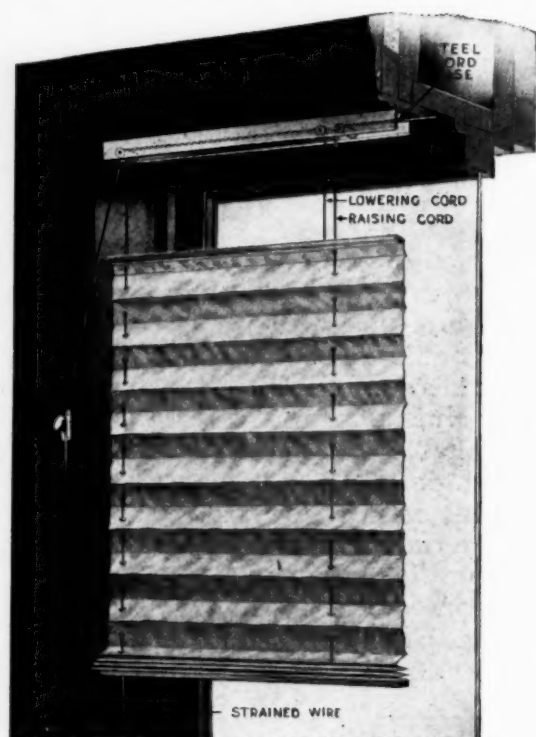
## Johnson Service Company

Main Office and Factory, Milwaukee, Wisconsin

AUTOMATIC TEMPERATURE CONTROL FOR 39 YEARS  
TWENTY-EIGHT BRANCHES UNITED STATES & CANADA



## Athey Perennial Window Shades



**Cost a little more originally  
but a lot less in the end**

If you were to disregard all the other advantages of Athey Perennial Window Shades, and buy on cost alone, they should still be your choice. Because while the original cost is a trifle more the cost per year of their life is far less than any other shades you can buy.

Athey Perennial Shades are good for many years. Many of the first ones manufactured—more than ten years ago—are still in use, and in good condition. They are made of indestructible cloth—thoroughly shrunk and water-proofed. Rain won't ruin them. And they can be dry cleaned.

*Let us provide you with facts and figures, and a list of fine buildings where they are installed.*

## Athey Company

6082 West 65th Street • Chicago, Illinois

\$250,000 by the Citizens' Aid Society of Minneapolis made possible the erection of the Christian Hospital which will specialize in the treatment of cancer. Gifts of \$20,000 by Mrs. Frank C. Todd; \$20,000 by Mrs. E. C. Gale, and \$5,000 by Mrs. Mapes made the nucleus of the Todd Hospital Fund.

### Nebraska

**Swedish Immanuel Deaconess Hospital Plans Addition.**—The Swedish Immanuel Deaconess Hospital, Omaha, will erect an addition at a cost of \$200,000.

**Grand Island Hospital Re-Opens.**—The Grand Island General Hospital, Aurora, which has been re-organized by Dr. H. B. Hoyden, physician in charge, was recently re-opened.

**New Wing for St. Catherine's.**—A new wing to cost \$150,000 and another story on the first unit will be added to St. Catherine's Hospital, Omaha, according to a recent announcement. The addition will more than double the capacity of the hospital bringing the total number of beds up to 180.

### New Jersey

**New Addition to West Hudson Hospital.**—A new sixty-bed addition to the West Hudson Hospital, Arlington, is being planned this summer.

**Bergen County Hospital Nurses' Home Opens.**—The new nurses' home at the Bergen County Hospital, Hackensack, was dedicated June 14.

**Homeopathic Hospital to be Removed to East Orange.**—The Homeopathic Hospital, Essex County, Newark, will be removed to East Orange in the fall.

**Overlook Hospital to Enlarge.**—Additional buildings, including a nurses' home and help's quarters, will be erected at Overlook Hospital, Summit. Mr. Charles F. Neergaard, New York, N. Y., is acting as consultant in the expansion program.

**Miss Ancker Resigns Superintendency.**—Miss Elizabeth Ancker, for several years superintendent, Burlington County Hospital, Mt. Holly, has resigned her position to become effective September 1. Mrs. Daisy Hollingshead, who has been with the hospital for a number of years, will succeed Miss Ancker.

### New York

**Directors Appointed for Mary Immaculate Hospital.**—Dr. George K. Meynen, has been appointed surgical director, and Dr. Charles A. Ross, medical director of the new Mary Immaculate Hospital, Jamaica.

**Bronx Hospital Opens to Women Interns.**—The Bronx Hospital has opened its doors to women interns by appointment to the staff of Drs. Pauline Seller and Anna Koslow, graduates of Bellevue Hospital Medical College.

**Supt. Dubin Goes to Mount Sinai, Philadelphia.**—Mr. Maurice Dubin, superintendent, The Bronx Hospital, New York, N. Y., for the past four years, has resigned in order to accept the superintendency of Mt. Sinai Hospital, Philadelphia.

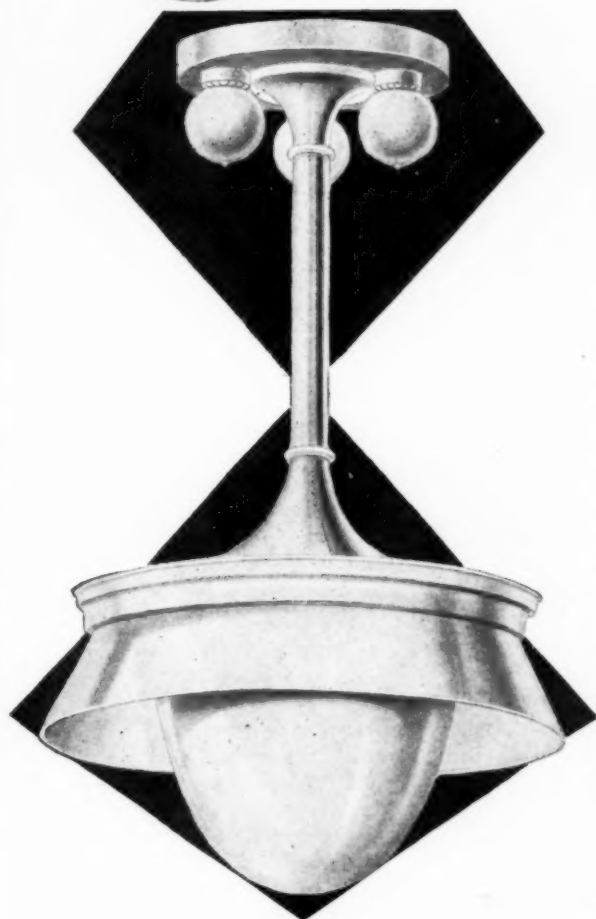
**To Superintend Children's Hospital.**—Mrs. Rye Morley Kinsey, formerly superintendent, Nursery and Child's Hospital, New York, will succeed Mrs. A. L. Ford, for the past seventeen years superintendent, Children's Hospital, Pittsburgh.

**Prepare for New Structure at Bellevue.**—The first step toward the erection of the new \$4,000,000 building at Bellevue Hospital, is being taken by the wrecking of some of the old buildings. The new building is to be known as pavilion F and G, and will be used for the treatment of neurological and foot diseases, and tuberculosis.

# The EDWIN F. GUTH COMPANY

DESIGNERS · ENGINEERS · MANUFACTURERS

## Lighting Equipment



## For the Operating Room

**N**O PART of the equipment of a modern operating room is more essential than a practical and efficient lighting fixture.

Made of white porcelain enamel and white glass, the unit shown opposite is especially adapted to service of this sort. Auxiliary lamps on the ceiling canopy provide soft, glareless illumination for the entire room while the center light under the reflector furnishes a large flood of semi-concentrated light on table or chair.

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Make demands on our Designing and Engineering Department, any time, for suggestions concerning special equipment.

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### TYPE "BF"

Type "BF" prices wired complete, except lamps. Finished all white; three porcelain receptacles in ceiling plate. Standard length, 60 inches. Extra lengthening, per foot, \$2.00.

	Spread	Dia. Bowl	Price
75 to 150 Watts.....	14"	9"	\$39.00
200 Watts.....	20"	11 1/2"	45.75
300 to 500 W. Mogul.....	26"	16"	60.25

Auxiliary lamps on canopy may be omitted if desired. A deduction of \$5.00 is made from the price of any size for such omission.

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2. The patient cannot soil the bed.
3. When you remove the pan you do so without danger of spilling the contents. You do not have to lift the patient from the pan.
4. Every surface of the pan is **VISIBLE**. It is easy to clean and sterilize.

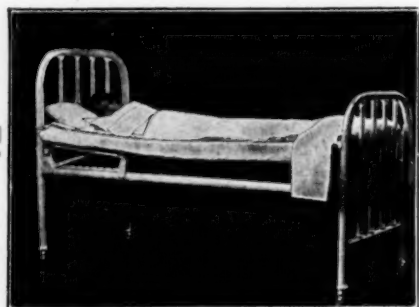
### This is the SANI-COMFORT a better bed pan.

The cushion is placed beneath the patient, the pan is then placed in position. Cushion is covered with water-proof material. The pan is white enamel with a hood to protect the bed.



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**VIT-O-NET MFG. CO.**  
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**Lay Cornerstone for United Israel Zion Nursing School.**—The cornerstone of the new nurse training school of the United Israel-Zion Hospital, New York, N. Y., was laid June 15. In response to an appeal from the Hon. Judge Geismar, master of ceremonies, on that occasion, approximately \$35,000 were realized in donations.

**Pathologic Chemist to University of Iowa Hospital.**—Dr. Victor C. Myers (Ph.D.) professor and director of the department of bio-chemistry, New York Post-Graduate Hospital for the past thirteen years, has resigned to accept the professorship of bio-chemistry at the State University of Iowa and pathologic chemist to the University Hospital, Iowa City, Ia.

### North Carolina

**Pitt Community Hospital Opens.**—The Pitt Community Hospital, Greenville, was opened June 1. The new institution is three stories high and will accommodate forty patients.

**Winston-Salem Memorial Hospital Opens.**—The new City Memorial Hospital, Winston-Salem, was opened to the public the first week of June. The new buildings bring the bed capacity of the hospital to 225.

### Ohio

**Plan Belmont County Sanatorium.**—The Belmont County Commissioners have let contract for a new \$175,000 county sanatorium building at St. Clairsville.

**New Annex for Findlay's Hospital.**—The new annex of Findlay's Home and Hospital, constructed by the city at a cost of \$100,000, was turned over to the hospital authorities, May 17.

**Dr. McGeorge to Succeed Dr. Miles at Salem City Hospital.**—Dr. James M. McGeorge, who has been vice-president and vice-chief of staff, Salem City Hospital, has succeeded the late Dr. F. T. Miles as chief of staff.

**Plan Nurses' Home for Children's Hospital.**—The site for a new nurses' home has been purchased for the Children's Hospital, Columbus, recently opened. The school for nurses will be opened in the fall. Dr. Marion B. S. Reynolds, has been appointed superintendent of the institution.

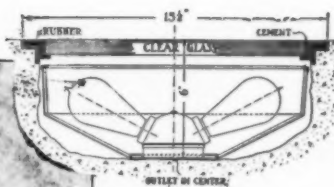
**Plan Purchase of Cherrington Hospital.**—Announcement has been made that a campaign to raise \$85,000 by public subscription which will be undertaken in Logan, for the purchase of Cherrington Hospital and its conversion into a community institution. An option has been secured for \$75,000 and the remainder of the fund to be raised will be used as a working capital.

**Purchase Site for Stark County Tuberculosis Hospital.**—The Stark County Commissioners have purchased a tract of land on the Louisville-Alliance Road as a site for the county tuberculosis hospital. The site selected met with unanimous approval, and is declared by the state department of health to be the best of more than twenty sites inspected. Tentative plans for the building have previously been prepared.

**People's Hospital Reorganizes.**—The People's Hospital, Akron, has recently been reorganized under the following departments; medicine, surgery, obstetrics; eye, ear, nose and throat; anesthesia; proctology; orthopedics; pathology and roentgenology. The active staff is composed of thirty-three members. The hospital has just added an obstetric wing of forty beds and made other additions to the total amount of \$200,000.

### Oklahoma

**Improvements for Eastern Oklahoma State Tuberculosis Sanatorium.**—Improvements costing nearly \$100,000 have



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To avoid such conditions, many hospitals are installing our floor lights.

Placed in passageways in either large or small wards, they distribute a soft pleasing and effective illumination.

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Apple Butter	Spanish Queen Olives	Mustard
Catchup	California Ripe Olives	Canned Meats

been made at the Eastern Oklahoma State Tuberculosis Sanatorium, Talihina. These include a recreational hall, electric light plant and additional wards.

### Pennsylvania

**Beaver County Sanatorium Dedicated.**—Beaver county's new tuberculosis sanatorium, the first of its kind to be equipped under state regulations, was recently dedicated.

**New Nurses' Home for Mt. Sinai Hospital.**—The Mount Sinai Hospital, Philadelphia, will erect a six-story nurses' home on Fifth Avenue and Reed streets, Philadelphia, at a cost of \$180,000.

**Miss Woodward to Superintendent Blair Memorial Hospital.**—Miss Viola Woodward, Norristown, has been elected superintendent of the J. C. Blair Memorial Hospital, Huntingdon, succeeding Miss Pena Snyder.

**Resigns as Superintendent of Germantown Hospital.**—Charles A. Gill, superintendent, Germantown Hospital for eighteen years, has tendered his resignation to take effect in the fall, to take up similar duties in the Episcopal Hospital, succeeding Capt. E. F. Laiper, resigned.

**Philadelphia General Hospital to Rebuild.**—The public health committee of the city council of Philadelphia recently approved plans for a \$4,000,000 rebuilding program for the Philadelphia General Hospital and the establishment of a metabolic clinic for the treatment of diabetes with insulin.

**Start Work on Shriners' Hospital for Philadelphia.**—Work has begun on the new Shriners' Hospital for Crippled Children, Philadelphia. A fund is being raised to build and endow the W. Freeland Kendrick Convalescent Home for Crippled Children, which will adjoin the Shriners' Hospital.

**Miss Keyes Leaves Christian H. Buhl Hospital.**—Miss Vera Keyes, directress of nurses, Christian H. Buhl Hospital, Sharon, has resigned her position and will reside at Sigourney, Iowa, where she and Miss Eweina McPherson, former head of the operating room staff, at the same hospital, plan to open a hospital. Miss Keyes will be succeeded by Miss Carrie Tucker, recently in charge of nurses at the Elizabeth General Hospital, Elizabeth, N. J.

**New Bronchoscopic Clinic for Philadelphia General Hospital.**—A bronchoscopic clinic is to be established in the Philadelphia General Hospital, according to the recent announcement of Dr. Wilmer Krusen, director of public health, Philadelphia. The clinic will be a duplication of the same resources now maintained in the Jefferson Hospital, and Dr. Chevalier Jackson and his assistant, Dr. William F. Moore, Jefferson, will serve as consultants.

### South Carolina

**New County Hospital for Newberry.**—A new county hospital will be erected at Newberry, at a cost of \$40,000.

### South Dakota

**Dr. Bury Takes Over Geddes Hospital.**—Dr. Charles L. Bury, Parker, has taken over the hospital conducted by the late Dr. Frederick E. Fyle, Geddes.

### Tennessee

**Beverly Hills Sanitarium Opens.**—Beverly Hills Tuberculosis Sanitarium, just out of Knoxville, was recently opened. The sanitarium contains five buildings: administrative, service building, infirmary, convalescent cottage, and Junior League cottage for tuberculous children which will house sixty-two patients.



# Hospital Good Will

What kind of advertising do patients give your institution after leaving? Can they say:

"They did **everything** possible to make me comfortable!"

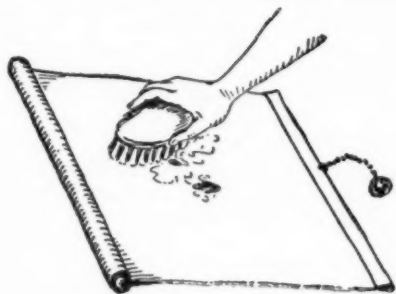
Convalescent Comfort is something the patient appreciates while at your hospital, and remembers long after leaving. She is sure to tell her friends all about it.

Among the agents contributing in no small way to the convalescent comfort of the patient is K-Y ANALGESIC. It makes for **hospital good will**.

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## Texas

**Dr. Homan to Erect Sanatorium at El Paso.**—A sanatorium will be erected in El Paso, at a cost of \$157,000, by Dr. Robert B. Homan.

**Plan Baylor County Hospital.**—Contract has been awarded for the erection of a hospital at Seymour, for Baylor County, at a cost of \$32,000.

**Plan Hospital for Tuberculous Children.**—The James Autry, Jr., Memorial Hospital and School will be erected near the present tuberculosis hospital, Houston, at a cost of \$50,000.

**Enlargements Planned for Jefferson Davis Hospital.**—The new Jefferson Davis Hospital, Houston, plans the erection of a \$25,000 nurses' home, a \$25,000 isolation ward, and a venereal disease clinic costing \$10,000.

**Fort Sam Houston to Have 600 Bed Addition.**—Additional buildings of a permanent character to house 600 patients are being planned for the General Hospital, Fort Sam Houston. The recommendations also include plans for an adequate laboratory equipment to meet the needs of the hospital equipped to handle approximately 1,000 patients.

## Vermont

**Nurses' Home for Heaton Hospital.**—A new nurses' home will be erected at Heaton Hospital, Montpelier, at a cost of \$50,000.

## West Virginia

**St. Edward's College to Become Hospital.**—St. Edward's College Highlawn, is to be converted into a hospital. Alterations and additions to the extent of \$12,000 are now being undertaken to make ready for the admission of patients.

## Wisconsin

**Addition for St. Agnes' Hospital.**—A new wing is now under construction at St. Agnes' Hospital, Fond du Lac, which will double the capacity of the hospital. It is expected to have the addition ready for occupancy next winter.

## Wyoming

**Wyoming General Hospital Superintendent Resigns.**—Miss Ida May Stanely, superintendent, Wyoming General Hospital, Rock Springs, has resigned her position.

## Canada

**Kiwanians to Donate Building for Tuberculous Children.**—The Kiwanians are erecting a building for the Children's Memorial Hospital, Montreal, Que., to be devoted to the housing of tuberculous children.

**Notre Dame Hospital Nears Completion.**—The new Notre Dame Hospital, Montreal, Que., is nearly completed, and will soon be ready for occupancy. The property on which the hospital is being built is the gift of the late Sir Rodolphe Forget. Dr. Oscar F. Mercier, will be medical superintendent.

## Mexico

**Dr. Bingham in Charge of Hospital Americano-Latino.**—Dr. William J. Bingham, Denver, Colo., is now in charge of the Hospital Americano-Latino, Puebla.

## Foreign

**New Manila Hospital to Fight Malaria.**—A hospital has recently been opened at Del Carme in the sugar mills district sixty miles north of Manila. The hospital will care for the surgical cases of Pampanga and Bataan, on the Island of Luzon and will also be the headquarters for the Rockefeller Foundation and the Philippine Health Service in their campaign for the control of malaria.